EAST REGION
TRAUMA PLAN FY 2002-03

East Region Trauma Plan 2002-03

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Revised December 2001

Submitted By: Kenneth A. Karnes, Regional President

Adopted By: Chairs & Executive Committee
East Region Committees & Regional Council

Prepared By: Kim Burke, Administrative Assistant
Jack Hendrix, IPPE Coordinator
Dawn Wright, Program Manager
Minors In Prevention

Adams
Asotin
Ferry
Garfield
Lincoln
Pend Oreille
Spokane
Stevens
Whitman

East Region EMS & Trauma Care Council
5521 N. Wall
Spokane, WA 99205

Phone: (509) 326-6499
Fax: (509) 326-6579
E-Mail admin@eastregion-ems.org
Web Site www.eastregion-ems.org

Acknowledgements

The East Region EMS & Trauma Care Council would like to acknowledge its many hundreds of EMS/TC providers, both prehospital and hospital, as well as the dispatchers/call takers, Injury Prevention and Public Education presenters, the Inland Empire Training Council, rehab providers, Medical Program Directors, each county EMS/TC council, and all of our partners in the EMS and Trauma System.

The East Region staff would like to take this opportunity to again thank ALL of the volunteers who are dedicated to making sure that the "right patient" gets to the "right facility" in the "right amount of time". The Regional Council, the Chairs & Executive Committee, and all of the other East Region committees have provided the technical assistance necessary to administer an effective EMS and trauma system in a region that covers over 15,000 square miles.

Thank You!

TABLE OF CONTENTS

Introduction

Summary of Proposed Changes ***iii***

Executive Summary ***iv***

Chapter I - Administrative Components

Leadership & Regional Council Operations **1**

* Organizational Chart **2**

Chapter II – System Development

A. System Development, Maintenance & Evaluation **6**

B. Local Government Ordinances **7**

C. Local System Development Costs **8**

Chapter III – System Operation Components

Overview& Data Tables **13**

Minors In Prevention **16**

Head Smart **21**

Reach Out With Hope – Suicide Awareness **23**

Safe & Sober Roadways **25**

Regional Library **27**

Chapter IV - Prehospital

A. Communications **28**

B. ***Medical Direction of Pre-Hospital Providers*** **38**

C. ***Prehospital EMS & Trauma Services Personnel*** **41**

D. Verified Aid and Ambulance Services **51**

**** Min/Max Table B*** **108**

E. Patient Care Procedures (PCPs) & County Operating Procedures (COPs) **111**

F. Multi-County or County/Inter-regional Prehospital Care **113**

Chapter V – Designated Trauma Care Services **114**

***** *Min/Max Table C* **117**

Chapter VI – Data Collection & Submission **119**

Chapter VII – EMS & Trauma System Evaluation **121**

Addendums

A. Licensed and/or Verified Aid and Ambulance Services (Updated to include Creston)

B. Patient Care Procedures

Washington State Department of Health

Emergency Medical Services and Trauma Prevention

FY 02-03 BIENNIAL PLAN FORMAT

INTRODUCTION
SUMMARY OF PROPOSED CHANGES WITHIN THIS REGIONAL PLAN, WHICH REQUIRE SPECIFIC DEPARTMENT APPROVAL*: (ONE PAGE MAXIMUM)*

- **<u>SPECIFY ALL REQUESTED CHANGES</u> CONTAINED WITHIN THIS PLAN IN THE FOLLOWING AREAS:**
- (1) Recommended numbers of department-approved verified prehospital services within the region;
- (2) Recommended numbers and/or levels of department-designed trauma services and/or rehabilitation services within the region;
- (3) Current department-approved regional patient care procedures and/or county operating procedure appendices to current department-approved regional patient care procedures;
- (4) Request(s) for department approval of regional council-adopted higher-than-state minimum standard(s), for implementation within the region

1. Please review county Needs and Distribution of Services reports and regional recommendations for min/max numbers of verified services.

    a. Explanation of changes to min/max numbers included in TABLE B.

2. NO RECOMMENDED CHANGE TO DESIGNATED MIN/MAX NUMBERS. TABLE C. ADDED TO CHAPTER 5.

3. Please review the Regional PCP #7 – Helicopter Response that was adopted by the Regional Council on June 13, 2001.

    a. No inclusion of Dispatch Protocols to PCP #7. The committee will review for appropriateness during this contract period. PCP #1 – Dispatch of Medical Personnel includes *state guidelines.*

4. The East Region DOES NOT have any council-adopted higher-than-state minimum standard(s), for implementation within the region.

5. Local Ordinances Section will be updated within the next six months and submitted under separate cover for review and approval. Input from county EMS/TC councils will be required for this section.

6. Additions of data tables and target numbers have been included in the IPPE Section. This section will be reworked for the next plan review.

7. Appropriate changes were made to the Communication Section of the plan. The old information will be updated at the next plan review. Goals and objectives will be worked on by the committee for inclusion into the plan.

The Regional Council and its working committees are committed to ensuring the effectiveness of the East Region Trauma System. Changes to the Executive Committee were made in December 2000 at the Annual Meeting. Kenneth A. Karnes was elected to the position of Regional President and Lisa Foster was elected Executive Secretary.

The council continues its commitment to prehospital agency licensing and verification. There are currently 69 licensed (including 2 in Idaho) prehospital agencies in the East Region. Sixty-seven of those agencies are verified. Creston Ambulance in Lincoln County, a volunteer agency, continues to be the only prehospital agency in the region that has not achieved verification status. Moscow Fire Department is also licensed in the State of Washington, however does not have verification status. The Prehospital and Transportation Committee has revised the current Verification Process and Checklist form used in the East Region for agencies seeking initial verification. The document provides the committee with information not currently being asked on the DOH verification application.

The Prehospital and Transportation Committee has worked diligently with county EMS/TC councils in the development of Needs and Distribution of Services reports that reflect the recommendations of minimum/maximum numbers of verified prehospital agencies within the region. Many of the response area maps have been updated. The committee has also worked closely with Northwest Medstar in the revisions of the Regional Patient Care Procedure for Helicopter Response. This document was submitted to the DOH in May 2001.

The Regional Council hosted one initial three-day Emergency Medical Dispatch (EMD) class on May 16 – 18, 2001. A one-day update class on protocol #11 was provided on May 21, 2001. Only 10 students attended the initial EMD class and 8 attended the update class. Information from Medical Priority Consultants indicates that the national turnover rate for EMD is around 80%. Here in the East Region the turnover rate is actually *less than 10%*. The Communications Committee is currently researching the need for annual training. It is possible that, because of the low turnover, the Regional Council may host EMD classes every other year rather than on an annual basis.

Since the resignation of Sr. Maureen Healy in December 2000, the Health Care Facilities Committee has been undergoing reorganization. The Regional Council would like to see the committee's composition consist of facility trauma coordinators. Trauma Coordinators (or other trauma professionals) from all nine counties and the State of Idaho will be represented on the new committee. The council is pursuing the option of being able to use tele-conferencing for committee meetings.

There have been very few changes in designation during the last two years. In December of 1999, St. Joseph's Regional Medical Center located in Lewiston, Idaho, received a Level III trauma pediatric designation. Last year, Pullman Hospital upgraded from a Level IV adult trauma center to a Level III adult trauma center. Gritman Hospital in Moscow, Idaho, designated a Level III adult trauma center, requested release from the Washington State Trauma System upon the designation of Pullman Hospital. St. Luke's Rehabilitation Institute remains the only rehabilitation trauma designated facility in the region with a designation of Level I adult and pediatric center.

The Injury Prevention and Public Education (IPPE) Committee and the Regional Council have continued to sponsor and coordinate various IPPE programs throughout the region. Regionally approved IPPE programs include: 1) Child Passenger Safety; 2) Head Smart; 3) Reach Out With Hope; 4) Safe and Sober Roadways and Mock Crash presentations; 5) Regional Resource Library; and 6) Minors In Prevention (MIP) and My Choice alcohol awareness programs. A full-time program manager was hired in October for the MIP program. A part-time employee was hired at the end of October to manage the Mock Crash presentation held at area high schools.

The East Region is very proud of the progress made in both prehospital and hospital data collection. The East Region currently submits approximately 80% of all prehospital data to the state registry. Only about 20% of prehospital data statewide is currently being collected. Although the Department of Health (DOH) has changed the submission process so that transport services leave a copy of the run report at the hospital upon patient delivery, the Regional Council has not indicated any change in data collection at this time. Prehospital agencies are still sending their data to the County Data Collection Sites, which in turn submits trauma and medical data to the Regional Data Collection Site. This process, established in 1996, has been very effective in this region. The Regional Council is

maintaining its current data collection process however does plan to support the newly established DOH submission process and any organized processes to improve data collection statewide.

The Regional Council continues to contract with the Inland Empire Training Council (IETC) to provide CME/OTEP and Patient Care Procedure training to the rural EMS providers of the region. The IETC continues to be recognized for its excellence and committed approach to education. Two ILS classes, sponsored by the Regional Council, were held in Lincoln and Whitman Counties this year. The committee, realizing that a lack of funds would not allow for additional prehospital training, is seeking outside funding for additional classes.

The Levels IV and V trauma designated facilities have met the requirements for acute care trauma training. The larger facilities, Levels II and III, provide training resources for the smaller facilities as well as provide training for their own personnel.

During the next biennium, the Regional Council will uphold the integrity of the EMS and trauma system by:

- Reviewing Regional PCPs and COPs and providing training to prehospital providers;
- Reviewing facility minimum/maximum recommendations for designated facilities;
- Working with county EMS/TC Councils to review Needs and Distribution of Service reports for each county, to include recommendations for minimum/maximum numbers of verified prehospital agencies;
- Reviewing verification applications, if appropriate;
- Hosting EMD training, if needed;
- Providing training for data collection, if necessary;
- Continuing to provide CME and OTEP to prehospital providers;
- Pursuing and utilizing grants to enhance safety for public and emergency responders

This document has been written as a business plan. Goals, objectives and strategies have been written in a manner that will allow extraction of specific information for the purpose of writing grants. The Training and Education Committee actually extracted information from the plan and used it to write a grant for additional training during this next year. Many of the goals will continue to involve research and development of programs prior to actually being able to implement the goal. The East Region EMS and Trauma Care Council will recognize its successes and strive to develop further aspects of emergency and trauma care. *The spirit and teamwork of this region will be its backboard.*

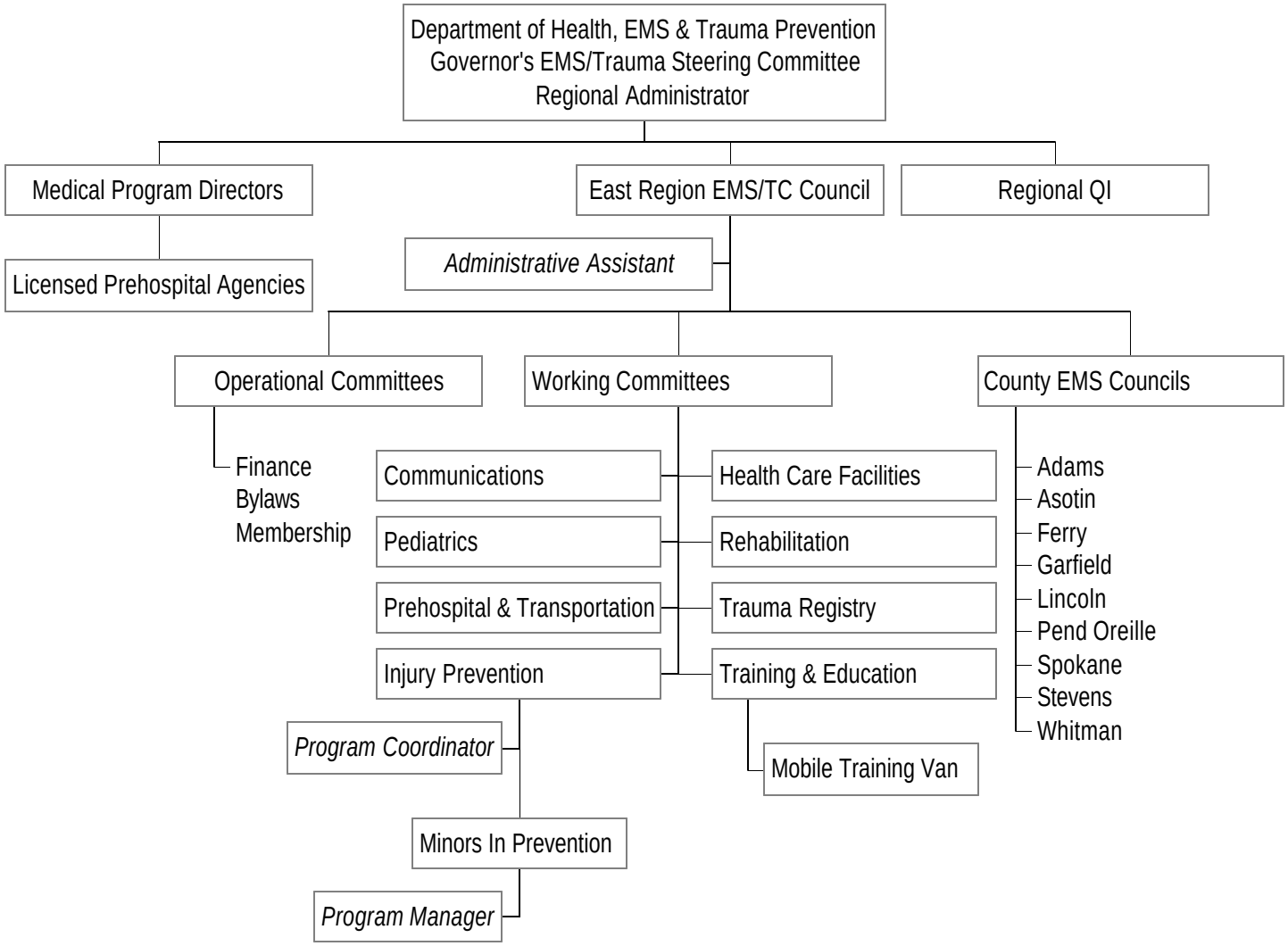
Welcome to the East Region!

A. Leadership – *Describe only if there are changes in the Regional Council's roles and responsibilities, including a "graphic representation" (organizational chart) of the relationship and interrelationships between the Regional Council as a lead agency and other organizations within the region which are involved in providing information and/or services relating to the successful implementation and operation of the regional EMS and trauma care system. Include involvement with professional and consumer groups, relationships with local, state and federal government agencies, and involvement with other non-profit and private sector groups and organizations within the region.*

Mission Statement: To establish and promote a system of emergency medical and trauma services, which provides for timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury. We recognize the changing methods and environment for providing optimal emergency care under varied conditions throughout the State of Washington.

- There have been no changes in the Regional Council's role and responsibilities to the successful implementation and operation of the regional EMS and trauma care system in the East Region. Please see approved trauma plan 2000 for additional information.

East Region
Organizational Chart



B. **Council Operations –** *If there is any difficulties with the current internal operations of the Regional Council. Describe what changes will be made and discuss how those operations relate to the statutory responsibilities of the Council. Discuss the board (regional council) and committee structure, and how these relate to internal operations in regard to fulfilling the Regional Council's contractual obligations.*

COUNCIL STRUCTURE

The Regional Council President also acts as the Regional Administrator. The Regional Council Membership consists of representatives from county and Idaho prehospital agencies, from the Level II, III, IV and V trauma designated facilities, as well as representation by elected officials, consumers, law enforcement agencies, government agencies, medical resource (MPDs), physicians, private ambulance services, urban-suburban fire departments, rehabilitation facilities, training agencies, helicopter services, emergency management agencies and regional committee chairs. For each member position there is also an alternate position. Their individual county council recommends candidates for each member and alternate position.

STAFF ACCOUNTABILITY

Effective January 1, 2001, all staff report directly to the Regional President.

- The Administrative Assistant works with the President, the Chairs & Executive Committee and all other committees and their chairs, with the exception of Injury Prevention and Public Education.

- The Minors In Prevention Program Manager also serves as the Assistant Injury Prevention Coordinator and works directly with the Injury Prevention Coordinator, as well as the Injury Prevention and the Minors In Prevention Committees.

- The Injury Prevention Coordinator position has been vacant since August 31, 2001. When this position is filled, the employee will work directly with the Injury Prevention Committee; however will continue to report to the President for personnel issues.

    - It is likely that a new coordinator will be hired after January 1, 2002.

- The council has in its employ a part-time Safe & Sober Roadways Coordinator, who works approximately 12 hours per week. All other staff are salaried.

COMMITTEES/COUNCIL OPERATIONS

Working and operational committees are defined in the bylaws. Each regional working committee has representation on the Regional Council by their committee chair. The committees are empowered by the Regional Council to administer their portion of the contractual agreement the East Region has with the Department of Health. Recommendations from these committees are brought forward to the Regional Council for formal action. The Administrative Assistant is also the Contract and Grant Manager and works closely with all committees except the Injury Prevention and Public Education Committee and its programs.

EXECUTIVE COMMITTEE

The authorized number of members of the Executive Committee shall be five (5) to six (6). The Executive Committee shall consist of the President, Vice-President, the Past President (if accepting of such an appointment), Secretary, Treasurer, and one other member of the COUNCIL to be appointed by the President at the annual meeting who shall hold this position for a one-year term until the next annual meeting where a successor will be appointed.

Officers: The officers of the corporation shall be elected at the annual meeting by the Council from their own membership and shall be: President, Vice President and Secretary and Treasurer. The same person shall not hold, at the same time, any two offices. (A Member at Large is appointed by the incoming President.)

- **Term of Office**: Each officer shall hold office from the time of their election for a term of one year until the next annual meeting where their successors will be elected and qualified. No officer shall hold any office for more than three (3) successive one-year terms.

DUTIES OF OFFICERS

- **President**: The President shall be the Chief Executive Officer of the Corporation and shall preside at all meetings of the COUNCIL. The President shall, subject to control of the COUNCIL, have general management of the Corporation and shall execute, on behalf of the corporation, all written instruments that are appropriate to carry out the policy that has been approved by the COUNCIL. The Regional President, after communicating with the Chairs & Executive Committee, shall be responsible for all personnel issues.

- **Vice President**: The Vice President shall, in the absence of, or disability of the President, perform the duties and exercise the powers of the President and perform such other duties as determined by the COUNCIL.

- **Secretary**: The Secretary shall record, or cause to be recorded, the minutes of all meetings and supervise the care for the records and papers belonging to the COUNCIL, including its charter; shall ensure that members of the COUNCIL are notified as to the time and place of each meeting and announce the program of the meeting. The Secretary shall keep the books and records of the COUNCIL and shall, with the President, sign and attest to all certificates when such signature or attestation is necessary.

- **Treasurer**: The Treasurer of the COUNCIL shall have the custody and control of the moneys of the corporation. The funds of the COUNCIL shall be disbursed as may be ordered by the COUNCIL, taking proper vouchers for such disbursements. The Treasurer shall render to the President, or the Executive Committee, at regular meetings, or whenever they may require it, an account of all his/her transactions as treasurer and of the financial condition of the COUNCIL. All checks or drafts drawn against the funds of the COUNCIL shall be signed by person or persons designated by the COUNCIL.

- **Past President**: The Past President may serve on the Executive Committee. The Past President may chair any meeting at which the President and Vice-President are absent. The Past President may assume such other duties as are assigned to him or her by the President.

- **Member At Large**: To be appointed by the President at the annual meeting. Duties as assigned.

OPERATIONAL COMMITTEES

- **Finance Committee:** The East Region Finance Committee shall prepare budgets, audit or procure an audit of the books of the corporation when appropriate, and give guidance to the Council regarding the allocation of whatever funds may become available.

  - ✯ The Finance Committee shall provide the Regional Council with a detailed disclosure of funds received and disbursed for the fiscal year, at the Annual Meeting (or sooner, if available), for review and approval.

- **Bylaws Committee:** The Bylaws Committee shall work with the COUNCIL to maintain the Bylaw document as a working document by which the COUNCIL is able to function as a working business. This Committee realizes the Bylaws will need to be re-addressed on an ongoing basis.

- **Membership Committee:** The Membership Committee shall identify and post vacant council positions region-wide. This Committee shall follow state guidelines and those set forth in the Bylaws and other COUNCIL documentation referring to membership that, with the Department of Health, will aid the Council's overall membership.

WORKING COMMITTEES

- **Communications Committee:** The Communications Committee works towards the enhancement of communication for Emergency Medical Services and trauma within the nine counties of the East Region.
  - This committee has been inactive over the past year, however reactivation plans are being made for January 2002.

- **Injury Prevention & Public Education Committee:** Develop prevention programs, based on regional needs that will reduce the number of needless deaths and injury in the region.

- **Health Care Facilities Committee:** Coordinate with the regional health care facilities to achieve the goal of providing the highest quality of care to trauma patients. The Committee will work toward the development of strategies to ensure a commitment to the availability of personnel, equipment, and provider education.

  - This committee has been inactive over the past year, however plans are being made to reactivate the committee in January 2002.

- **Pediatrics Committee:** Facilitate standardization throughout the spectrum of trauma care for pediatric patients, regardless of urban vs. rural locale.

  - Originally, when this committee was formed, it was a hospital based Pediatric group that met once a month at Sacred Heart Medical Center. At the resignation of its chair, the committee became inactive. There has been some discussion about reactivating this committee and making it provider based to include both hospital and prehospital providers. No decisions have been made at this time.

- **Prehospital & Transportation Committee:** Develop methods and establish criteria, which will be used to identify the need, the recommended distribution and level of care of verified pre-hospital services in the East Region. Review, revise and develop Regional Patient Care Procedures as needed. Review, and make recommendations for revisions or development of County Operating Procedures. Review (with recommendations and/or comments where appropriate) applications for licensure, verification and affiliation of prehospital services.

- **Rehabilitation Committee:** Establish the role of rehabilitation in provision of East Region trauma care; to identify existing resources for rehabilitation services from acute care through community reintegration; to establish networks to enhance communication, consultation and the scope of rehabilitation services; and to support collection and interpretation of registry data.

- **Training & Education Committee:** Provide for the centralized management and coordination of training within the East Region.

  - This committee has undergone a change in its leadership within the past few months.

- **Trauma Registry Committee:** This Committee has been focusing on developing and implementing a process by which all licensed prehospital agencies within the region are submitting data to the state registry in a timely manner.

  - This committee has not been extremely active over the past year, however the committee chair serves as the Regional Council's Data Specialist and works directly with the Prehospital & Transportation Committee.

A. EMS/TRAUMA SYSTEM PLAN DEVELOPMENT, MAINTENANCE AND EVALUATION

Provide a short statement on how the region:

1. Conducts needs assessments and identify resources

In the spring of each fiscal year, needs assessments are conducted using a number of surveys, statistics, questionnaires and inventory of resources. Through these efforts and through studies completed by the state, gaps in resource availability, training and education, equipment and communication systems are determined. These assessments provide the focus for developing a plan that builds on the strengths and existing trauma resources and addresses the weaknesses of the current system. Prehospital agencies, county EMS/TC councils and health care facilities actively participate in regional surveys and questionnaires. The death and hospitalization statistics, provided by the DOH, are the foundation for the IPPE strategies.

2. Develops EMS and trauma plan

It is the Regional Council's goal is to develop a trauma plan with a focus on long-term vision. The East Region's EMS/TC plan is developed through the combined efforts of the Regional Council, Committee Chairs and their committees, and many other volunteers representing both hospital and prehospital services located throughout the nine-county region. County EMS/TC Councils work diligently throughout each fiscal year to complete projects that are included in the region's trauma plan, such as Distribution of Services and min/max recommendations for verified prehospital services.

Once a schedule is put together for plan review, each committee has approximately 3 months to review, revise and update appropriate sections of the plan. Committees are then asked to do a final review of the plan 30 days prior to the final copy going to the Regional Council for full review and approval.

3. Implement the approved regional plan

The East Region's EMS/TC System was implemented in Spokane County on August 1, 1995. Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman Counties implemented the trauma system on September 1, 1995. Full implementation of the trauma system in Whitman County occurred in January 1997 after health care facility designations were completed. Notification of an approved regional plan is mailed to the appropriate entities upon receiving official notice of plan approval from the Department of Health, EMS & Trauma Prevention. The plan, once approved is placed on the DOH, EMS & Trauma Web site as well as on the East Region Web site. Copies are available upon request.

4. Reviews and evaluates how the plan is working

Since the submission of the 1991 Plan, the East Region has become actively involved in making the EMS/TC Plan a "living document", overseeing changes and updates as required. The plan is reviewed constantly for deficiencies, which are then addressed by the appropriate committee. In some cases, addendums to the plan are submitted to the Department of Health for approval during the biennium, at which time those addendums become an official part of the plan.

Each section of the plan is reviewed by the appropriate working committee (IPPE, Communications, Training & Education, Prehospital & Transportation, Health Care Facilities & Rehab, etc.). The plan format and a copy of the evaluation is provided to each committee prior to review and updating. The committees review the goals and objectives to determine which are appropriate to work on during a specific fiscal year. Revisions recommended by the committees are then made.

Once the appropriate committee chair has authorized the changes/updates/revisions to the plan section, a recommendation is then forwarded to either the Chairs & Executive Committee or the Regional Council for final plan adoption. (This process depends entirely on whether the Regional Council or the Chairs & Executive Committee is scheduled to meet during that particular month. If the Chairs & Executive Committee approves the plan, it is generally with prior approval of the Regional Council. Once the plan or updated section is approved by the Steering Committee, it is distributed to the committee and to the appropriate entities. This

process allows the committees the opportunity to determine how well the plan is working and what areas need to be addressed. After the plan has been approved, all entities involved in the East Region EMS and Trauma Care System are notified and the plan is made available everyone, either via mail and or web posting.

B. **LOCALGOVERNMENT ORDINANCES:** *Discuss any **new** local ordinances that may apply to the operation of local EMS/TC systems within the region. Discuss how these ordinances effect the future operation of local systems and their relationship to the regional EMS and trauma care system.*

- **This section will be updated to include revised ordinances (if any) and information on Public Hospital Districts and other information relative to the operation of local EMS/TC systems within the region prior to June 30, 2002. The document will be submitted separately from the current plan revisions.**

Asotin and Spokane Counties in the East Region have local ordinances in place. These ordinances give the EMS councils the responsibility of overseeing county Emergency Medical Services. These counties make recommendations to local government regarding duplication of service and other issues related to EMS and trauma care. Copies of these ordinances are on file in the East Region office. *According to county EMS/TC councils, there are no new ordinances in this region that would govern EMS and trauma.*

C. **LOCAL SYSTEM DEVELOPMENT COSTS:** *Specify components of local system development and project costs of implementation, including potential source(s) of funding for those local costs.*

Overview - Local System Development

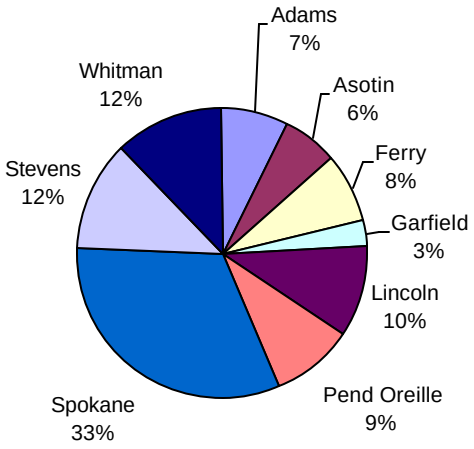
The Regional Council, has during the past six years, developed a methodology for determining regional and county system development costs. It is more difficult to calculate anticipated local system development costs because of the diversity of available funding. Prehospital services in seven of the nine counties in the region are supported by EMS levies. Generally EMS levies are allocated to a specific service/agency, as you will see listed in the chart on the next page. Spokane and Asotin County Councils are for the most part supported by paid staff. The other seven county councils are supported by volunteer in-kind contributions.. There are many EMS response areas that do not have a population to support an EMS levy.

When possible, the Regional Council tries to support local EMS/TC grants. Many rural prehospital agencies rely on the Needs Grants Process, where the Department of Health allocates funding directly to the agency. It is difficult to anticipate what projects the grant applications may be. Currently, a $1,200 participation grant is awarded to each prehospital agency annually if it participates in the state registry. Nearly all of the East Region prehospital services participate in this grants process.

The chart below indicates each county's local system development costs as outlined on the table on the next page. Each county EMS/TC council and/or a specific agency identifies projects relative to the EMS and Trauma System.

LOCAL SYSTEM DEVELOPMENT

Local System Development Costs 2002-03 Biennium $ 85,602,190



1.A. Prehospital EMS & Trauma Services – Volunteer In-Kind $36,374,832 Annually

The Prehospital Volunteer formula below was developed and updated by the Regional Advisory Committee in 2001 in order to determine statewide in-kind services provided by prehospital providers. This formula has been updated to reflect $15.00 per hour.

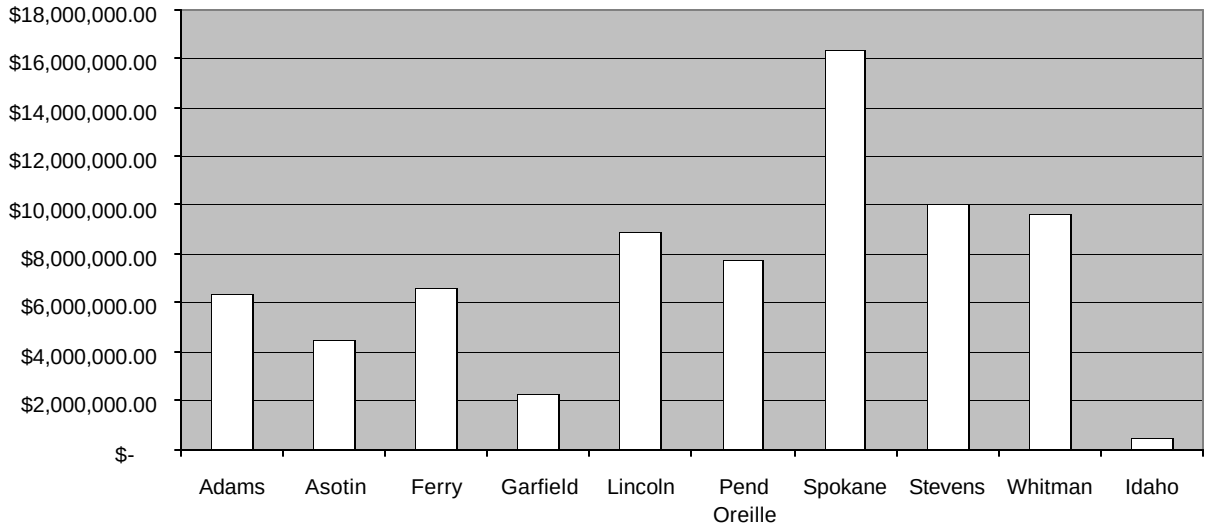
PREHOSPITAL PROVIDER IN-KIND CONTRIBUTION FORMULA

$15,600 (Salary calculated at 1040 hours x $15.00) X 3 people X number of vehicles X % of volunteers X 12 months = In-kind Service for EMS prehospital providers for one year.

COUNTY	NO. VEHICLES	VOLUNTEERS	IN-KIND
Adams	6	94%	$ 3,167,424.00
Asotin	6	66%	$ 2,223,936.00
Ferry	6	98%	$ 3,302,208.00
Garfield	2	100%	$ 1,123,200.00
Lincoln	8	99%	$ 4,447,872.00
Pend Oreille	8	86%	$ 3,863,808.00
Spokane	31	47%	$ 8,182,512.00
Stevens	10	89%	$ 4,998,240.00
Whitman	10	86%	$ 4,829,760.00
Idaho	6	7%	$ 235,872.00
Annual Totals	**93**		**$ 36,374,832.00**
Anticipated Biennium Totals			**$ 72,749,664.00**

Source: Licensing & Certification provided data on number of vehicles and volunteer provider percentage.

BIENNIAL VOLUNTEER IN-KIND CONTRIBUTION = $72,749,664



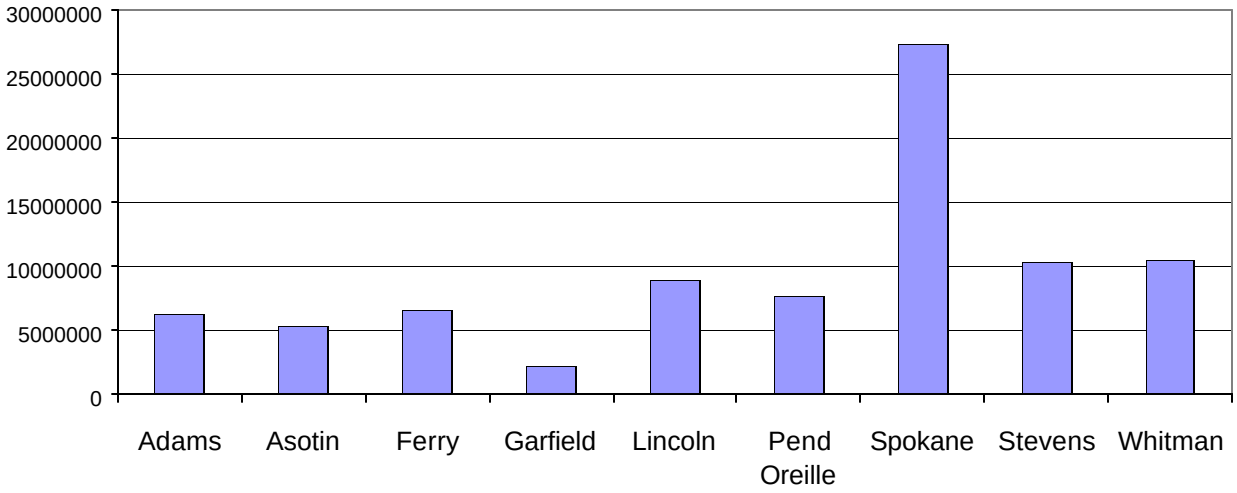
LOCAL SYSTEM DEVELOPMENT COSTS B Y COUNTY

County	Description	Funding Source	Amount	Yearly Total Amount	Biennium Total Amount
Adams	Prehospital Care	In-Kind	$3,167,424		
Adams Totals			**$3,167,424**	**$3,167,424**	**$6,334,848**
Asotin	Local Council	Contract	$500		
	City of Clarkston	EMS Levy	$221,202		
	City of Asotin	EMS Levy	$6,500		
	Asotin Co. EMS District	EMS Levy	$225,332		
	Prehospital Care	In-Kind	$2,223,936		
Asotin Totals			**$2,677,470**	**$2,677,470**	**$5,354,940**
Ferry	Local Council	Contract	$500.00		
	City EMS	EMS Levy	$7,354		
	Fire District #1	EMS Levy	$29,471		
	Prehospital Care	In-Kind	$3,302,208		
	Trauma Registry	In-Kind	$540		
Ferry Totals			**$3,340,073**	**$3,340,073**	**$6,680,146**
Garfield	Local Council	Contract	$500		
	Prehospital Care	In-Kind	$1,123,200		
	Trauma Registry	In-Kind	$300		
Garfield Totals			**$1,124,000**	**$1,124,000**	**$2,248,000**
Lincoln	Local Council	Contract	$500		
	Fire District #1	EMS Levy	$21,503		

	City of Sprague	EMS Levy	$5,840		
	Prehospital Care	In-Kind	$4,447,872		
Lincoln Totals			**$4,475,715**	**$4,475,715**	**$8,951,430**
Pend Oreille	Local Council	Contract	$5 00		
	Fire District #1 (2001-2003)	EMS Levy	$4,700		
	Prehospital Care	In-Kind	$3,863,808		
Pend Oreille Totals			**$3,868,508**	**$3,868,508**	**$7,737,016**
Spokane	Local Council	Contract	$500		
	City of Spokane	EMS Levy	$4,253,733		
	City of Cheney	EMS Levy	$124,000		
	City of Medical Lake	EMS Levy	$42,500		
	Fire District #2	EMS Levy	$16,861		
	Fire District #4	EMS Levy	$267,264		
	Fire District #8	EMS Levy	$525,500		
	Fire District #10	EMS Levy	$237,689		
	Fire District #11	EMS Levy	$8,392		
	Fire District #13	EMS Levy	$50,826		
	Prehospital Care	In-Kind	$8,182,512		
Spokane Totals			**$13,709,777**	**$13,709,777**	**$27,419,554**
Stevens	Local Council	Contract	$500		
	Fire District #1	EMS Levy	$167,255		
	Prehospital Care	In-Kind	$4,998,240		
Stevens Totals			**$5,165,995**	**$5,165,995**	**$10,331,990**
Whitman	Local Council	Contract	$500		
	City of Albion (6 year)	EMS Levy	$6,492		
	City of Pullman (Permanent)	EMS Levy	$365,933		
	Fire District #7 (6 year)	EMS Levy	$28,694		
	Fire District #12 (6 year)	EMS Levy	$25,248		
	City of Palouse (6 year)	EMS Levy	$15,506		
	Prehospital Care	In-Kind	$4,829,760		
Totals			**$5,272,133**	**$5,272,133**	**$10,544,266**
Grand Totals				**$42,801,095**	**$85,602,190**

- Source: County auditor, treasurer and/or assessor's offices 6/01.
- Volunteer in-kind contributions are calculated at $15.00/hr.
- The fire departments/districts listed on these two pages were the only ones sited by the county auditors to benefit from county EMS levies.

Local System Development Costs
Biennium 2002-03 = $85,602,190



OVERVIEW

The East Region EMS/TC Council has a number of Injury Prevention and Public Education Programs that are sponsored by the Region.

- Minors in Prevention (MIP) is a hands-on educational program targeting youths 13-20 years old and endeavors to reduce high-risk behaviors in youth associated with alcohol and/or drug use and poor choice decision making, thereby limiting the likelihood of traumatic injury or death potentials for young people.
- The Head Smart program helps to educate school-age children on the use of bicycle helmets.
- Reach Out With Hope (ROWH) is a suicide awareness program that targets young adults between the ages of 13-21. The ROWH program is currently being updated to include current data.
- Tread to Safety is a falls prevention program that is currently being updated.
- The Safe & Sober Roadways program is an alcohol awareness program promoted by Mock Drunk Driver Crash presentation and other forms of presentation to high school and sometimes Jr. High School age youth.
- Child Passenger Safety: The Regional Council has elected not to take a lead on this program at this time. This section has been deleted from the original writing of this document because the Council is not coordinating it.

The tables below share data about fatal injuries and non-fatal hospitalization. Comparisons are made between the East Region and the State of Washington. Tables 4 and 5 show the top three causes of injury/fatality within the region by county.

Table 1: East Region Non-fatal Hospitalizations Vs. Fatal Injuries

Non-fatal Hospitalizations			**Fatal Injuries**		
Cause	**Rate**	**Age**	**Cause**	**Rate**	**Age**
Falls	318.7	85+	MVA	12.2	18-19
MVA	53.6	18-19	Suicide w/firearms	8.8	75-84
Self Inflicted Non-Med. Poisoning	55.4	15-17	Falls	7.3	85+

Source: Developed by IPPE TAC 1/25/2000

Table 2: East Region Non-fatal Injuries Vs. Washington State Non-fatal Injuries 1990-1999

East Region			**Washington State**		
Cause	**Count**	**Rate**	**Cause**	**Count**	**Rate**
Falls	17304	326.6	Falls	151460	282.8
MV - Occupant	3741	70.6	MV - Occupant	31881	59.5
Suicide - Poisoning	2468	46.6	Suicide - Poisoning	22671	42.3
Struck by or Against	1430	27	Struck By or Against	12312	23

Source: Washington State Dept. of Health, Center for Health Statistics, Death Certifications

Table 3: East Region Fatal Injuries Vs. Washington State Fatal Injuries 1990-1999					
East Region			Washington State		
Cause	Count	Rate	Cause	Count	Rate
MV - Occupant	647	12.2	MV - Occupant	5774	10.8
Suicide - Firearms	467	8.8	Suicide - Firearms	42014	7.8
Falls	373	7	Falls	2967	5.5
Homicide - Firearms	124	2.3	Suicide - Poisoning	1475	2.8

Table 4: East Region Non-fatal Hospitalizations by County 1990-1999			
County	Cause	Count	Rate
Adams			
	Falls	438	294.7
	MV - Occupant	153	103
	Struck by or Against	36	24.2
Asotin			
	Falls	437	231.2
	Suicide - Poisoning	68	36
	MV - Occupant	42	22.2
Ferry			
	Falls	254	365
	MV - Occupant	125	179
	Struck by or Against	28	40.2
Garfield			
	Falls	40	170.6
	MV - Occupant	7	29.9
	Struck by or Against	6	25.6
Lincoln			
	Falls	532	562.6
	MV - Occupant	104	110
	Poisoning & Struck by or Against	21	22.2
Pend Oreille			
	Falls	384	371.3
	MV - Occupant	140	135.4
	Suicide - Poisoning	46	44.5
Spokane			
	Falls	12833	328.6
	MV - Occupant	2463	62.8
	Suicide - Poisoning	1971	50.3
Stevens			
	Falls	1364	392.5
	MV - Occupant	488	140.4
	Suicide - Poisoning	148	42.6

Whitman			
	Falls	972	242.2
	MV - Occupant	219	54.6
	Struck by or Against	183	45.6

Table 5: East Region Fatal Injuries by County 1990-1999

County	Cause	Count	Rate
Adams			
	MV - Occupant	37	24.9
	Suicide - Firearms	10	6.7
	Falls	7	4.7
Asotin			
	MV - Occupant	23	12.2
	Suicide - Firearms	22	11.6
	Falls	18	9.5
Ferry			
	MV - Occupant	24	34.5
	Suicide - Firearms	21	30.2
	Fire, burns asphyxia	6	8.6
Garfield			
	MV - Occupant & Suicide -firearms	5	21.3
	Struck by or Against	1	21.3
		6	25.6
Lincoln			
	Suicide - Firearms	16	16.9
	MV - Occupant	14	14.8
	Falls	9	9.5
Pend Oreille			
	MV - Occupant	35	33.8
	Suicide - Firearms	14	13.5
	Falls	8	7.7
Spokane			
	MV - Occupant	370	9.4
	Suicide - Firearms	313	8
	Falls	277	7.1
Stevens			
	MV - Occupant	88	25.3
	Suicide - Firearms	45	12.9
	Falls	36	10.4
Whitman			
	MV - Occupant	51	12.7
	Suicide - Firearms	21	5.2
	Falls	14	3.5

The information on the following pages describes in detail each of the current programs implemented by the Regional Council.

MINORS IN PREVENTION – DRUG AND ALCOHOL AWARENESS

A. CURRENT STATUS - *Briefly describe the program and identify the resources available used within the region.*

Minors in Prevention (MIP) is a hands-on educational program targeting youths 13-20 years old and endeavors to reduce high-risk behaviors in youth associated with alcohol and/or drug use and poor choice decision making, thereby limiting the likelihood of traumatic injury or death potentials for young people. The program was initiated in August 1998. Since that time over 850 youth have been referred to the program, with a completion rate of 86%. Youth referrals are generated from local Juvenile, District and Municipal Courts as well as schools, public defenders, attorneys, and parents. Anyone in the community may refer youth to the program. Youth are paired with volunteer mentors who assist them throughout the month and accompany them to a hospital visitation as well as two monthly classes.

Youth complete a 10-hour program which includes an orientation, coroner's presentation and tour of the morgue, WPS impairment discussion, Trauma Medics/Think First Presentations, a victim/survivor's story, a 4-hour hospital visitation on a Friday or Saturday evening, debriefing session with guest speakers on dependency issues, self-esteem, goal setting, etc. Program evaluations are completed by all students as well as pre and post tests regarding perceptions of alcohol/drug use, and decision-making issues. Youth also complete a 500-word essay regarding their experiences with each of the Program components.

Multi-agencies, entities and volunteers throughout the Region volunteer their time and resources to speaking, mentoring and assisting the many aspects of the program assist the program.

We have obtained seed monies through our contract with the Department of Health (grant from WTSC) to begin MIP program(s) in rural counties within the Region. Much discussion and planning has taken place in Ferry County, working with the Job Corp. Their current projected plan is to bring students to Spokane for the three monthly sessions, provide their own staff to be trained as mentors. They will facilitate weekly contacts between their staff mentors and students in an effort to accurately identify and redirect at-risk behaviors and attitudes among their student population.

B. STRENGTHS AND WEAKNESSES - *Discuss the strengths and weakness of this program to include an assessment of additional needs within the region.*

Strengths

- The Program interfaces with multiple agencies as partners and referral sources
- Strong referral system from Juvenile & District Courts
- Referrals generated from rural areas including Ferry, Pend Oreille, Stevens, and Lincoln Counties
- Positive, committed role models from volunteer mentors and speakers
- Comprehensive - multi-faceted areas of impact – focus areas include safety restraint use, impairment education, consequences of drug and alcohol use/abuse, smart choice education, tobacco prevention, suicide awareness, anti-violence education, refusal skills, self-esteem, morals, values, goal setting, etc.
- Interactive - provides "hands-on" experiences, hospital visitations where students interact with patients and staff, wheel chair exercise, interaction with hospital staff
- Graphic – real-life issues/situations are presented truthfully
- Provides opportunities for youth to experience success vs. failure
- Provides youth an opportunity for a "second chance, i.e. deferred sentences, etc.
- Provides opportunities for victims/survivors to share their experiences with at-risk youth
- Provides volunteers with a sense of belonging, and an opportunity to give of themselves
- Provides volunteers with valuable experience and training working with at-risk youth and multiple agencies

- An extensive number of referrals on a continual basis are available – there are always youth participating in high-risk behaviors
- Flexibility – within the program structure, many aspects of the program are flexible, able to meet ever-changing needs of students and volunteer staff
- Mentor training assisted by "shadowing" of seasoned program mentors and program partners
- Scholarship assistance is available to those in need

Weaknesses/ Needs of the Program

- Support staff would greatly benefit flow of work, and increase availability of Program Manager to pursue advertisement campaigns aimed at promotion of program and volunteer recruitment through the use of newspaper ads, billboards, public service announcements, etc., recruit and retain speakers, train mentors as well as take vacation, sick leave, etc.
- Volunteer base is not always adequate – more students than mentors available
- Class size limited due to mentor/student ratios
- Class size limited due to facility space and availability
- Program cost can be prohibitive for low-income families, additional scholarship fund assistance needed
- Training of volunteers and mentors limited by funds available:
  - More comprehensive training of mentors needed to address multi-faceted needs of at-risk youth
  - Training to address personal protection for volunteers and staff
- Availability of Program Manager to travel to counties within the Region to assist in planning & implementation of additional MIP Programs
- Availability of adequate equipment (lap-top computer) to make available presentations and materials to prospective referral agencies, volunteer prospects, prospective program partners

C. DEMOGRAPHICS - *Identify specific demographics of the region that drive this IPPE program development in the region.*

Studies in 1998 and 1999 from WTSC CHARS, Abuse Trends in WA State 2000 Report and FARS report the following:

- Motor vehicle crashes are still the leading cause of death for American teenagers, despite on-going education efforts
- Young people ages 15-20 make up 6.7% of the total driving population in this country but are involved in 14% of all fatal crashes
- 21% of youth ages 15-20 involved in passenger vehicle fatalities had been drinking
- 30% of Washington vehicle fatalities involving drivers ages 15-20, involved excessive speed
- From 1994-1998 441 deaths were reported in the East Region
- In Spokane County alone, 2,321 injuries were reported during the same time period with 213 deaths and 1,571 injuries
- Crashes actually ranked #2 as the cause of all non-fatal injuries and ranked #1 as the main cause of fatalities within the East Region
- Two-thirds of people killed in Washington traffic crashes were unrestrained; three out of four would have survived had they simply been wearing their seatbelts
- From 1994 through 1999, 359 motor vehicle occupants within the East Region died as a result of a crash; 65% of the occupants were unrestrained or improperly restrained
- A higher percentage of Washington State students in grades 8, 10 & 12 had tried alcohol and marijuana than their counterparts nationally
- 54.1% of high school seniors had used an illicit drug at least once in their lifetime
- Over one in twenty (5.6%) of today's high school seniors are daily marijuana users
- 60% of smokers start by the age of 14; 90% are firmly addicted before reaching age 19
- Only one in ten smokers become addicted after the age of 19
- 386 people in the East Region died as a result of suicide during years 1994-1998 (WA DOH); these numbers do not begin to reflect the number of attempted suicides that never seek professional help

Young people's lifestyles, jobs, extracurricular activities, late-night socializing, experimenting, testing of limits, risk-taking and the use of alcohol and drugs continue to increase the mortality rate among youth and young drivers, despite programs of awareness and education. An urgent need to prevent needless tragedy and death remains evident.

D. GOALS, OBJECTIVES & STRATEGIES

GOAL 1: Prevent And Reduce High Risk Behaviors In Youth Which Are Associated With Alcohol And/Or Drug Use, And Poor Choice Decision Making, Thereby Limiting The Likelihood Of Traumatic Injury And/Or Death Potentials For Young People Ages 13-21.

A. Maintain and expand the efforts of the Minors in Prevention program and activities throughout the East Region.

- Provide alternative to sentencing, "second chance" program for youth referred by Juvenile and District court system.
- Recruit, train and retain appropriate community volunteer mentors for at-risk youth.
- Advertise and promote the Minors in Prevention program throughout the Region and assist with creation of new programs throughout the Region.
- Provide statistical data relating to recidivism, effectiveness of program and its presentation.
- Provide scholarship assistance to low-income, at-risk youth.
- Research and apply for funding using local, state and national resources.
- Recruiting of appropriate adult volunteer mentors and speakers will be assisted through the use of newspaper, journal and magazine advertisement, job resource agencies, bulk mailings, oral, written and PowerPoint presentations to corporate, public and private entities.
- Training of mentors will be facilitated through the use of PowerPoint presentations, speakers, monthly newsletters, written and oral presentations, photocopied materials, making funds available for volunteers to attend appropriate conferences, classes, and seminars relating to injury prevention and at-risk issues.
- Retention of mentors will be facilitated by the use of mentor recognition in the form of gifts, awards, special event parties, program apparel, t-shirts, hats, jackets, mugs, pens, etc.
- Promotion of the program to the Region will be accomplished through the use of oral, written and PowerPoint Presentations. Seed monies will be provided to areas wishing to implement their own program(s) and/or combine with the current MIP Program. Travel and subsistence funds will be provided to the Program Manager and designated volunteers to facilitate this endeavor.
- Statistical data regarding recidivism and program effectiveness will be collected in the form of pre/post test data and recidivism survey. A database to effectively track recidivism will be implemented within the biennial time period.
- Scholarship assistance will be made available to all low-income, at-risk students in need. Students requesting scholarship assistance will be required to submit requests in writing by completing Minors in Prevention Scholarship application. Scholarship funds will be disbursed until funds are exhausted. Scholarship funds will be solicited from sources outside of the Program.

Provide education aimed at producing healthy attitudes and behaviors associated with: alcohol and drug use, smoking, safe use of vehicles, appropriate safety restraint use, suicide awareness and prevention, the dangers of sleepy drivers, tobacco prevention, violence prevention and character issues and making smart choices limit the likelihood of injury and death potentials for young people today.

- Provide monthly 10-hour smart-choice education and mentoring program to youth ages 13 through 20 involved in high-risk, poor choice behaviors.

- Ensure continued positive, supportive relationships with hospital program partners through use of recognition gifts, certificates, notes, correspondence and personal visitations of Program Manager.

- Research and provide additional areas of outreach to student population ages 13-20.

- Research and provide education/training/support to parents of at-risk youth population.

- Eleven 10-hour monthly classes will be held each year, to include two three-hour educational sessions and one four-hour hospital visitation. Referrals will be accepted from all Court agencies and appropriate documentation will be provided to agencies regarding compliance/non-compliance of youth referred.

- Educational presentations will be made during monthly classes through the use of PowerPoint presentations, speakers, will include but not be limited to: Think First, Trauma Medics Talk Tough, Smart Choices, Washington State Patrol, Sheriff's Department, Liquor Control Board, County Medical Examiners, Reach Out With Hope, victims and survivors, slide shows, video presentations, demonstrations, written and printed materials, brochures, etc.

- Educational presentations will be made to Regional Junior, Senior and Alternative High Schools to promote the program as well as solicit program participants and program partners. Travel and subsistence funds will be provided to the Program Manager and designated volunteers to assist in this endeavor.

- By June 30, 2003 approximately 750 youthful offenders between the ages of 13 - 20 will take the Minors in Prevention program.

- By June 30, 2003 approximately 225 youthful offenders between the ages of 13-18, referred to the program by Diversion, will complete the My Choice program (the first 3 hours of the Minors In Prevention program).

- By June 30, 2003 approximately 220 parents will have experienced the first three hours of the Minors In Prevention program.

Projected Costs

Continuation of and enhancements to the Minors in Prevention Program

Volunteer In-Kind Contributions	$ 56,750
MIP Operational Expenses	78,349
Projected Cost FY 02	**$135,099**
Projected Cost Biennium 02-03	**$270,198**

E. ACTIVITY MEASUREMENT

- At the beginning of each new class, each participant will be provided with a pre-test to measure attitudes and behaviors concerning impaired driving, drinking and poor choice behaviors. At the conclusion of the

program each participant will be given a post-test to see if their perceptions concerning the above attitudes have changes.

- Participants will also be provided with a Program Evaluation to determine effectiveness of the Program and each specified program component, speakers, etc. Required student essays are also used to measure effectiveness of program, value of mentors and program components.

- Each participant and program volunteer mentor will be provided with an evaluation to be completed at the conclusion of the hospital visitation to determine effectiveness of the visitation, strengths, weaknesses, perceptions of students, interaction with hospital staff, etc.

- Recidivism surveys will be provided to participants over a specified time frame following completion of the program in an effort to determine if behaviors/attitudes have changed as a result of the program and if the participant has re-offended.

- Volunteer satisfaction surveys will be distributed to program volunteers and mentors to obtain information regarding effectiveness of each program component, obtain ideas and resources to augment current program and to assist in determining program strengths and weaknesses.

- Hospital staff surveys will be explored to determine strengths, weakness and needs of each hospital unit as their staff relates to program volunteer mentors, staff and student participants.

HEAD SMART

A. CURRENT STATUS: *Briefly describe the program and identify the resources available used within the region.*

Helmet use/education per se is not a program that is coordinated by the East Region. Rather, we support other agencies throughout the Region in their endeavors to promote helmet use in all sports wear helmet use would reduce injury and/or death. Utilizing grant funding we purchase bicycle helmets and along with our partnership with the Spokane Safe Kids Coalition and the Spokane Regional Health District we advertise the availability of the helmets to emergency service agencies, schools, and medical facilities.

B. STRENGTHS AND WEAKNESSES: *Discuss the strengths and weakness of this program to include an assessment of additional needs within the region.*

Rather than operating as lead agency in this program the Region is working as a partner with the Spokane Safe Kids Coalition and the Spokane Regional Health District in the distribution of the helmets to agencies that request them.

Being accomplished via the East Region's web site the grant application process for helmets is virtually paperless. That can be a weakness also because there are rural communities within the region that do not have access to the Internet. Yet the announcement of the availability of the grant describes ways around that problem (local library or the East Region office.)

While the grant application notice went out to 75 hospital and pre-hospital agencies throughout the Region, only 21 applied for the helmets. This leads us to believe that there are areas within the Region that do not have a helmet use program.

C. DEMOGRAPHICS: *Identify specific demographics of the region that drive this IPPE program development in the region.*

From 1994 through 1998 309 people in the East Region were hospitalized due to injuries from a bicycle crash (Source; WA. Dept. of Health). A study conducted by the East Region Injury Prevention and Public Education Committee in 1995 showed that the majority of children (ages 1-14) "never" wear a helmet. The main reason parents noted for lack of use was cost.

D. GOALS, OBJECTIVES & STRATEGIES: *Identify the East Region EMS/TC Council system's long term and short term goals, objectives, strategies and projected costs to improve this IPPE program.*

GOAL: The goal of this program is to increase the proper use of helmets. Our intention is to put helmets on the youth of the Region and educate them regarding the importance of their use. Increasing the use of helmet wear will reduce the risk of head injury by at least 85% if the rider was involved in a traffic crash. With the vast majority of the East Region being rural, the cost factor can weigh heavily on a person's decision to use one.

The East Region will distribute mini-grant applications to each of the emergency service organizations in its service area requesting the following information prior to consideration:

1) Describe the need in your area for increasing the use of bike helmets.
2) What age group can your organization help?
3) What do you plan on doing to help with the problem - state program goal(s)?
4) How will you accomplish your goal? List and describe activities that will explain your program.
5) When will you distribute the requested helmets and complete your project? Please give dates for beginning, doing and completing the major activities.

Approximately 3,000 helmets will be distributed to school age children within the nine counties of the region by September 30, 2003.

In addition, the Region will have available bicycle "safety rodeo" kits for use by any organization desiring to hold one. The Region will also have available a number of bicycle safety educational materials such as videos, hand puppets (Buckle Bear™), coloring books and pamphlets.

Because of our partnerships with the grantees and the Safe Kids Coalition we are able to greatly expand the scope of our coverage. Instead of one person/agency in 9 counties we are utilizing multiple agencies and people to disseminate materials and education.

Projected Costs

Continuation of and enhancements to Head Smart

Volunteer in-kind contributions	$2,025
Operational expenses	$28,572
Projected cost FY 2002	**$30,592**
Projected cost biennium 2002-2003	**$61,194**

D. **ACTIVITY MEASUREMENT***: For each identified short-term objectives provide measurable actions and program/activity evaluation plans for the coming biennium.*

Each mini-grant recipient will be required to complete a report for submission to the East Region at the end of the project. This report will be fashioned after the quarterly reports that are submitted to WTSC. The Region will in turn summarize the report(s) and submit it to WTSC. We will also use process evaluation and determine number of people reached by the number of helmets distributed. Each helmet given to an agency will in turn go to a child that did not previously have one. A child with a helmet in possession will wear it.

Following is the report that requests information from the agencies:

PROJECT REPORT

1) Applicant Agency:

2) Project objectives achieved. Refer to objectives section in approved application.

3) Problems Encountered:

4) Other Remarks:

Prepared by:

REACH OUT WITH HOPE (ROWH) – SUICIDE AWARENESS

A. CURRENT STATUS: *Briefly describe the program and identify the resources available used within the region.*

The Reach Out With Hope Suicide Awareness program is currently under revision. The program has not been updated since it's inception in 1996.
The program is designed to help educators and young people recognize the signs of suicide and enable them to learn how suicide can be prevented and where to seek professional help. In addition to the IPPE Coordinator there is a cadre of volunteers that have been trained in presentation of the program, utilizing slide or PowerPoint presentations that is available via the library.

B. STRENGTHS AND WEAKNESSES: *Discuss the strengths and weakness of this program to include an assessment of additional needs within the region.*

The ROWH program is very strong because of its presenters and the way that the program is delivered. The program is deliberate in its method of delivery. We use people that have had experience in Suicide (either as a profession or personally) and utilize a slide or PowerPoint presentation to illustrate some of the signs and symptoms of a person that may be considering suicide.

This program can be very emotional and may evoke powerful memories, especially if the presenter or audience member has had personal experience(s) with suicide.

The program has not been updated since 1996.

C. DEMOGRAPHICS: *Identify specific demographics of the region that drive this IPPE program development in the region*

From 1994 through 1998 386 people in the East Region died from suicide, 336 died as a result of a motor vehicle crash. Though more people died from suicide than crashes, suicide is a problem that is seldom heard about (Source: WA. DOH)

These numbers do not address the population that have attempted suicide but have not completed their attempt and never seek professional help

D. GOALS, OBJECTIVES & STRATEGIES: *Identify the East Region EMS/TC Council system's long term and short term goals, objectives, strategies and projected costs to improve this IPPE program.*

GOAL: The overall goal is to educate the community about the magnitude of the problem, warning signs, first aid tasks, and community counseling resources. This will hopefully reduce the number of suicides and attempted suicides.

There is a cadre of volunteers that have been trained in presentation of the program utilizing slide or PowerPoint presentations. They present the program, tell their own story (if there is one) and encourage discussion among the participants about the signs and symptoms of a person that may be considering suicide along with the first aid tasks.

The program will be marketed to Regional high schools and colleges with strong encouragement on training their own presenters and providing them with a copy of the PowerPoint presentation or slides.

There is a great need for the brochures that describe suicide signs, symptoms, first aid tasks and community resources. The cost of these would be $815 for 4000.

Future grants will have the money for brochures within along with travel funds and an allocation for a laptop computer for the PowerPoint presentations.

Approximately 400 students and 20 teachers will be reached through this program by June 30, 2003.

E. ACTIVITY MEASUREMENT

Attendees are given a pre-test prior to the presentation asking questions pertaining to their knowledge of suicidal behavior or gestures and if they would know what to do if a person would display any signs or symptoms relating to suicidal behavior.

Post presentation the same test is presented to measure if their knowledge of behaviors has increased and to see if they now know what to do if a person is possibly suicidal.
While this measures the short-term results the long-term results are measured via monitoring statistics in the Region.

SAFE AND SOBER ROADWAYS

A. **CURRENT STATUS** : *Briefly describe the program and identify the resources available used within the region.*

The program is designed to increase awareness about the dangers of impaired, sleepy and improperly restrained drivers. The Region is a resource that is available to assist with organization of mock car crashes and provides technical assistance such as moulage support and/or assistance with contact emergency service agencies.

The resources used are mainly personnel wise such as the volunteers that respond to the "crash" and the people that coordinate it. Within the Regional library the Trauma Nurses Talk Tough© slide presentation is available for emergency service agencies to utilize for presentations. In addition the moulage kit is available for use as necessary in addition to experience people to assist with the application.

B. **STRENGTHS AND WEAKNESSES** : *Discuss the strengths and weakness of this program to include an assessment of additional needs within the region.*

This program is very intense in that it shows the real life consequences of dangerous driving. Utilizing the professional aspect of the police officer and/or firefighter/paramedic as a speaker about responding to incidents, teamed with the survivor of a crash presents a very lifelike meaning to the penalty of impaired/dangerous driving.

All too often a community has recently experienced a fatality or similar tragedy due to an impaired and/or dangerous driver. This can cause reluctance to let the mock crash occur for fear that it will open old wounds.

C. **DEMOGRAPHICS** : *Identify specific demographics of the region that drive this IPPE program development in the region.*

From 1994 through 1998 there were 441 deaths that can be directly attributed to traffic crashes within the East Region. Fatalities are not the only problem; in the same time period there were 2,321 injuries with Spokane County having the bulk of both (213 fatalities and 1,571 injuries). Crashes actually rank #2 in the cause of non-fatal injuries in the East Region and is the #1 cause of fatalities. (Source: DOH)

D. GOALS, OBJECTIVES & STRATEGIES : *Identify the East Region EMS/TC Council system's long term and short term goals, objectives, strategies and projected costs to improve this IPPE program.*

GOAL: Working within some of the emphasis areas of Target Zero (Age Extremes, Impaired Drivers and Sleepy Drivers) the goal of Safe and Sober Roadways for Washington is to reduce the number of fatalities and injuries caused by traffic crashes.

Operating with the Department of Health's Injury Prevention and Public Education Technical Advisory Committee and other safety agencies and coalitions (such as the Spokane County Traffic Safety Commission, Highway 2 Traffic Safety Corridor, Think First, Trauma Medics Talk Tough, and Trauma Nurses Talk Tough along with others) the East Region would like to significantly reduce the number of fatalities and injuries caused by crashes and work toward the Target Zero goal.

Utilizing PowerPoint presentations, slide shows and video from the Sober Roadways for Washington and Trauma Nurses/Medics Talk Tough we will use a team of emergency service personnel (firefighters, police officers, paramedics/EMTs, and emergency department nurses) to present the program. Supporting them will be victims of crashes to give "real-life" meaning to the consequences of impaired and/or dangerous driving. Upon request we will also provide a mock-drunk driving crash. These crashes will work in conjunction with the slide/video presentation. Upon completion of the slide/video presentation attendees will file outside and observe an actual emergency service response to a staged motor vehicle crash.

These crashes are highly orchestrated to the point that unknown bystander can see the actor portrayal and not know that is actually staged. The emergency service personnel In addition, the East Region will offer training sessions to community and school leaders on how to set-up and stage their own mock collision (with East

Region support). These presentations will be advertised throughout the East Region focusing on high schools because the majority of the crash victims are in the 18 to 19 year old age group.

Through the Safe & Sober Roadways Mock Crash presentations the region anticipates reaching approximately 5,000 students and 400 teachers by September 30, 2002.

Projected Costs

Continuation of and enhancements to the Safe and Sober Roadways Program

Volunteer in-kind contributions	$86,880
Operational expenses	$41,216
Projected cost FY 2002	**$128,096**
Projected cost biennium 2002-2003	**$256,192**

E. **ACTIVITY MEASUREMENT:** *For each identified short-term objectives provide measurable actions and program/activity evaluation plans for the coming biennium.*

Prior to each presentation/mock crash we will provide all attendees with a pre-test to measure their attitudes and behaviors concerning impaired/dangerous driving. Once the presentation/mock crash has concluded the attendees will be give a post-test to measure the effectiveness of the program and to see if their perceptions concerning impaired/dangerous has changed. Each attendee of the training session will be given a form to complete to determine the effectiveness of the training and will be notified that the East Region will be contacting them monthly to determine if any mock crashes have been held of if there are plans to hold any. This information can also be submitted via e-mail or on a form that will be on the East Region's web site.

REGIONAL RESOURCE LIBRARY

A. CURRENT STATUS : *Briefly describe the program and identify the resources available used within the region.*

The library is a source of videos, pamphlets, posters, training materials and other objects available to any person or agency in the Region. The main source of the materials is via organizations that offer free materials. Other more substantial items (such as the moulage kit, Trauma Roo costume and Buckle Bear) were either gifts or were obtained via grant monies.

The library is in constant demand, material from it get used at each Minors In Prevention class as well as at each car seat check-up. In addition requests are continually received for items to place at a booth or table at various safety events within the Region.

B. STRENGTHS AND WEAKNESSES : *Discuss the strengths and weakness of this program to include an assessment of additional needs within the region.*

The library is quite diverse. There are items pertaining to just about any injury prevention activity imaginable. In addition, there are substantial items available for a person or agency to sign-out that in many cases they cannot afford or have no need to purchase. These items include but are not limited to a multi-media projector, Trauma Roo costume, and Buckle Bear puppet and moulage kits.

The library does not have a budget; most of items within are either acquired via free sources or purchased utilizing funds from a program with established funding.
At times a request for an injury prevention item will be made that is not in the library, is there is no funding for the item and it cannot be obtained for free then we cannot make it available.

C. DEMOGRAPHICS : *Identify specific demographics of the region that drive this IPPE program development in the region.*

With a population of 561,100 (1999 census data) the injury prevention needs in the East Region are quite varied. As such it is necessary to keep a varied amount of materials on hand to meet the injury prevention educational requirements of the Region.

D. GOALS, OBJECTIVES & STRATEGIES *: Identify the East Region EMS/TC Council system's long term and short term goals, objectives, strategies and projected costs to improve this IPPE program.*

GOAL: The library's goal is to provide people and agencies literature, videos or physical equipment to meet their injury prevention needs.

This is accomplished by constantly being on the lookout for free injury prevention items that we can place in the library and by keeping it stocked with items pertaining to current East Region IPPE programs.

E. ACTIVITY MEASUREMENT: *For each identified short-term objective provide measurable actions and program/activity evaluation plans for the coming biennium.*
The activity of the library is measured in the number of times it is accessed or materials requested from it.

A.1. CURRENT STATUS : *Describe the current regional communications system including:*

In the early 1970's a VHF radio system was implemented statewide with funding through DSHS and Health Services Division from Traffic Safety Commission to assist hospitals and EMS/TC agencies purchase the radios. This system is known as the HEAR (Hospital Emergency Administrative Radio) system. There are two channels available for medical communications; the emergency frequency is 155.340 MHz, and the hospital administrative frequency 144.280 MHz. The emergency frequency is used for communications between prehospital responders and the hospital emergency departments. The administrative frequency is used for communications between hospitals for non-emergency type communications and coordination in a mass casualty event.

The HEAR system was a distinct advancement in the area of medical communications. It provided for on-line medical control. The system is serving EMS very well. However, with the passage of some fifteen years and the advancements in technology, the region's medical communications network needed to be expanded and improved to cover those areas in which providers have communication problems.

In 1994 the Regional Council sent a questionnaire to all county communication contacts in an attempt to identify specific information on equipment, training and shortfalls. As a result of this questionnaire, many improvements to the communications system were made.

VHF-UHF Crossband Repeater System

The East Region contains mostly VHF prehospital communications. It was necessary to update much of the old and deteriorating hospital base stations in the region before again re-evaluating the effect of prehospital communication.

It was found, in two major studies of the region, that the next step was to improve prehospital communication with medical control. The DOH Developed a communications system called MEDCOM, which would provide additional UHF radio frequencies to prehospital providers. In order for providers to use the MEDCOM system, radios would have to be re-programmed to the MEDCOM frequencies. The cost involved in re-programming the radios made the system unavailable to most providers in the region.

The East Region, however, still continues to use VHF system spectrum well, and needed a method of communicating into the MEDCOM Network without having to add additional radios at great expense to each provider. The VHF-UHF crossband repeater was developed to provide a means to communicate from a VHF ambulance or station to the UHF network. With simple reprogramming of the mobile and hand held radios in some stations, it was found that communications could be done efficiently without major expense.

A test site was constructed in both the Ferry County Project and Deep Lake Project through the Tri-County Communications Project Plan. The system has worked well, but still has limited access. The system has benefits for control stations and hospitals when the normal HEAR system is tied up in the large metros of the East Region, specifically in and around Spokane. The new system on MEDCOM provides an alternative method of communicating with wide area signal capability.

Another benefit of the crossband system is that it can be moved to other locations if need be, to provide for communication voids in the region. It is economically sound and proves a good investment as an interconnection to the state's MEDCOM System. The system will link the region's clinics to higher medical authority and in the long run will provide for better prehospital and medical care of our citizens.

Backup Communications System

The current backup system would be cell phone radio relay through dispatch, normal established telephone systems, cell phone direct to hospital or relayed through the dispatch center, local police agencies on-scene to relay to dispatch, or Washington State Patrol through pre-established phone and communications systems.

Improvements

Improvements to the 1974 communication equipment were made region-wide in 1995. New VHF base stations and/or antennas were placed at Newport Community Hospital at Cook Mountain; St. Joseph's Hospital at Chewelah; Mt. Carmel Hospital at Colville Mountain; Ferry County Memorial Hospital at Klondike Mountain; Whitman Hospital in Colfax; Deer Park Hospital & Medical Center in Deer Park; and Garfield Hospital District in Pomeroy.

Radio/Telephone equipment was installed at Deep Lake in Stevens County. The Tri-County Emergency Communications System, Inc. (Pend Oreille, Stevens and Ferry Counties) has assumed receivership rights of this project and has assumed full responsibility for annual maintenance and routine operation.

New radio/telephone equipment was installed at Fransen Peak near Curlew in Ferry County, in the spring of 1995. The system utilizes a UHF link relay on top of Klondike Mountain and by radio, additionally connected to Fransen Peak near Curlew, to a crossband device that will communicate with prehospital EMS/TC personnel called out on trauma incidents. The system utilizes a portion of the HEAR VHF spectrum and will connect to the Washington State's Trauma Communications Network using the Medcom channelization.

There have been no recent upgrades to the existing communications equipment since 1996.

A.1.a. PUBLIC ACCESS (e.g. #911, etc.)

E 9-1-1

In 1992, Washington State Enhanced 9-1-1 legislation mandated Public Safety Answering Points (PSAP) or 9-1-1 centers for all counties within Washington State by December of 1998.

In the East Region, over the past several years, citizen access to emergency agencies, police, fire and EMS has improved. In many counties consolidation of communication resources has helped to improve the efficiency of communications

A.1.b. DISPATCH: Include a discussion of:

A.1.b.1. Training For Dispatch Personnel

Although Emergency Medical Dispatch is a very significant aspect of the trauma system, it has only been within the last five to six years that a statewide effort has been made to train dispatchers and call-takers in Emergency Medical Dispatch. Communication Centers provide EMS/TC responders with vital information about the nature and the location of the emergency call to insure fast and accurate EMS response.

Prior to 1995, many Communication Centers in this region did not have adequate equipment or training to provide the type of dispatch necessary for the EMS and trauma system. Many centers used one or two line telephone systems for dispatch. Others were unable to dispatch EMS/TC providers to the scene unless they first contacted a prehospital agency with a mobile radio, which would transmit the necessary information to the EMS/TC providers. Still other communication centers did not realize the importance of recording incoming calls.

In the spring of 1995, the East Region EMS & Trauma Care Council adopted ***MEDICAL PRIORITY'S*** Emergency Medical Dispatch protocols and began an extensive training program for dispatchers region-wide. The East Region, with assistance from the State E 9-1-1 Center and the Washington State Criminal Justice Training Center (WSCJTC) has trained approximately 300 dispatchers and call-takers in Emergency Medical Dispatch between the 1995 and 2001. Dispatchers and call-takers are now allowed to provide Pre-arrival Instructions, where prior to 1995 only Spokane County allowed their dispatchers to provide this necessary information to callers. Today, eight of the nine East Region counties are 100% EMD trained. . Adams County, as far as the region knows, has not participated in any type of EMD training, although it is made available to all counties every spring when the East Region hosts at least one three-day initial EMD class. Pre-arrival instructions given by dispatchers to bystanders, using ***MEDICAL PRIORITY'S*** Emergency Medical Dispatch Protocols have improved not only the quality of EMD but also the way in which the communities view their dispatch centers.

In spring of 2001, the East Region will host one three-day initial EMD class and two one-day update classes.

A.1.b.2. Dispatch Prioritizing

Medical Priority's Emergency Medical Protocols have provided dispatchers and call-takers with the tools for dispatch prioritizing. The following system is used:

ALPHA → Check Welfare → FR* Resource → Code/No Code
BRAVO → Minor or Injured → Not Life Threatening → FR* Code → Ambulance - No Code
CHARLIE → Life Threatening → FR* Code → Paramedic Code → Ambulance Code
DELTA → Possible Imminent Death → Everyone Code
* First Responder

In the city of Spokane, the above dispatch prioritizing is something that is used every day. However, since there are very little Advanced Life Support services in the eight rural counties of the region, and because so many of the prehospital providers may be volunteers, dispatch prioritizing may not include all of the response options listed above.

A.1.b.3. Provisions For Bystander Care With Dispatcher Assistance

Citizen Access

Citizen access is most often provided when a member of the general public comes upon an emergency medical or injury incident and places an emergency phone call.

Telephone is the most common method used by the public to report emergency incidents. In this day and age of increasing technology, cellular telephones are used more and more.

- 9-1-1 emergency telephone is universally recognized and widely publicized, easy to remember and can be taught to very young children.

- Other methods used to access emergency medical response are citizen band and ham radios, marine radio, "walk-in", cellular telephone, alarm systems and hail-down of radio equipped public safety or utility vehicles.

During FY 99, the East Region's Prehospital & Transportation Committee felt a need to develop a *Citizen and Affiliate Agency EMS/TC System Access Policy*, which is shown below. The purpose in developing this policy was to identify how citizens and affiliate agencies should activate the EMS and trauma system. The Regional Council approved the policy on July 8, 1998.

CITIZEN AND AFFILIATE AGENCYEMS/TC SYSTEM ACCESS POLICY
Regional Council Approved, July 8, 1998

Citizen access to the EMS/TC system is most often provided when a member of the general public or personnel of an affiliated organization comes upon an emergency medical or injury incident and places a 9-1- 1 call.

Telephone is the most common method used by the public to report emergency incidents. Cellular telephones are increasing in use.

The 9-1-1 emergency telephone number is universally recognized, widely publicized, easy to remember, and can be taught to very young children.

Other methods used to access emergency medical response are citizen band and ham radios, marine radio, "walk-ins", alarm systems and hail-down of radio equipped public safety or utility vehicles.

Once a citizen and/or personnel of an affiliated agency have accessed the patient, 9-1-1 shall be contacted immediately in order to activate the EMS/TC system.

Affiliate Agency Definition: An affiliated service is an organization that is not required to be licensed under RCW 18.73, but may be recognized by the Department of Health as a participant in the EMS and Trauma Care System. Affiliated services provide response and/or care of patients in accordance with approved regional and state plans, regional/County Operating Procedures, and local prehospital Patient Care Protocols.

Tiered Response: Following the Region's plan to promote the concept of tiered response, the appropriate agency shall be dispatched per the standards outlined in the East Region Patient Care Procedure #1 - Dispatch of Medical Personnel that was implemented July 31, 1996.

A. 1.b.4. Patient Care Procedures (PCPs) Or County Operating Procedures (COPs) Developed To Improve Communications

Regional PCP #1 – Dispatch of Medical Personnel outlines the criteria for communications centers in dispatching the appropriate EMS personnel to the scene. A copy of this document is with the addendums. Some counties have similar COPs. Additional information is on file at the Regional office.

A.1.c. Primary Communications Systems

The HEAR VHF communications system is the primary communications system used in the East Region. It allows all prehospital providers to make contact with dispatch and medical control. There are still some areas of the region that have difficult reaching dispatch or medical control. The Prehospital Needs Grant program through the Department of Health offers EMS agencies the ability to seek funding to correct communications issues.

In the mid to late 90's the DOH, EMS and Trauma Prevention office installed a communication system statewide called the Medcom System. This system did not work in eastern Washington because of the resources available. The repeater installed at Mount Spokane has not been used by either of the level II or level III hospitals, not has it been used by any prehospital agencies in the region. The system has not been used in this region due to the expense involved in re-programming radios for these UHF frequencies.

Washington State Patrol provides the only backup/alternative communications in this region.

A.1.c. Backup/Alternative Communications System

The Washington State Patrol provides the current backup/alternative communications system. An alternate communications system would be the use of cell phone radio relay through dispatch, normal established telephone systems, cell phone direct to the hospital or relayed through the dispatch center, local police agencies on-scene to relay to dispatch, or Amateur Radio Emergency Services (A.R.E.S.) Hams.

A.1.d. Systems Integration - *Discussion of system operation during single patient, multiple-patient, mass casualty and disaster incidents, specifying ambulance to ambulance, ambulance to dispatch, and ambulance to hospital communications.*

Single Patient

Single patient, multiple-patient, mass casualty and disaster incidents are handled in much the same way when the call is received at the 9-1-1 centers.

1. Spokane County calls from the 9-1-1 Center are transferred to Spokane City Dispatch where all fire and EMS/TC calls are routed to the appropriate licensed/verified prehospital agency (first responder or ambulance).

2. In Spokane County, during a mass casualty or disaster, the Spokane City Dispatch Center would dispatch in the following order: 1) First Responder/Ambulance; 2) Police Department; 3) Deaconess Medical Center (Area hospital coordinator for disaster/mass casualty); and 4) Department of Emergency Management.

3. Rural Counties Dispatch: In the eight rural counties of the region, 911 call taking and dispatch is done through the Sheriff's Departments. The 9-1-1 centers are responsible to alert and/or dispatch police, fire and EMS units. Response modes (code/no code) are determined by County Operating Procedures, which relate to the Regional Patient Care Procedure #1 - Dispatch of Medical Personnel.

4. Deaconess Medical Center (also a joint level II designated facility) would begin coordinating area hospitals to determine availability/inventory of all area hospital beds and services. Smaller rural designated trauma centers would also call the area joint level II designated trauma center that is on-call, for this information.

5. Mutual Aid Agreements: In most counties, dispatchers and call takers know which agencies have mutual aid agreements and dispatch accordingly. Spokane County has mutual aid preplanned and programmed into CAD. Spokane County E 9-1-1 then makes a CAD entry to alert Law Enforcement for Mutual Response.

6. Police: In Spokane County, 9-1-1 monitors incoming calls after transfer to the Spokane Fire Department Combined Communications Center.

7. Department of Emergency Management: It is the responsibility of the Department of Emergency Management to coordinate all services needed in times of mass casualty and/or disasters.

MULTIPLE AGENCY ON-SCENE COMMUNICATIONS: *Include both public and private agencies, e.g., police to fire to ambulance.*

Overview

There are approximately 100 to 150 different agencies in the East Region who responds to EMS and trauma calls. Multiple agency on-scene communications refers to a function of the radio for mutual aid and use of a common frequency (districts sharing radio frequencies). For example, in Spokane County, American Medical Response accesses the fire districts First Responder tactical frequency. There is also shared use of frequencies with the Washington State Patrol.

Mass Casualty And Disaster Incidents

Area hospitals using the HEAR frequency (that is 144.280) will coordinate patient care and destinations. Local Departments of Emergency Management Services will assist in bringing in out of area resources. Local fire and EMS responders are training together and entering into mutual aid agreements for more timely response.

In addition, Spokane hospitals have been piloting RAMSES, the computerized software that alerts prehospital providers and other hospitals of department availability. The hospitals are discussing common terminology and will continue to meet to address issues of RAMSES. Each facility is working on their individual red and yellow status meanings. Compliance and legal personnel will be reviewing the hospital recommendations. They have found that RAMSES is a great teaching tool by putting updates, policies, procedures and web links on it for all to see and use.

Quality Management - *Describe the process for evaluating communication system providers and dispatch activities, including identifying strategies for upgrading current communication system(s).*

Prior to 1995 each communication center in the region provided its own way of evaluating communication system providers and dispatch activities. When the Regional Council began to sponsor EMD training region-wide, dispatchers began to learn about the technical/legal aspects of Emergency Medical Dispatch. Since that time supervisors in dispatch centers have become more aware of quality management of their providers and dispatch activities.

The Department of Health, EMS & Trauma Prevention has approved Washington State Guidelines for Emergency Medical Dispatch. These guidelines outline suggestions for quality management of providers and dispatch activities. These guidelines will be beneficial in communication centers establishing quality management of providers and dispatch activities.

A.1.e. Public And Private Agencies: (Police To Fire To Ambulance)

- Fairchild Air Force Base

  The public calls 911… → the calls go to Spokane→Spokane 911 notified police → police notify military police for initial injury → Fire Department at Fairchild AFB is notified if the call is fire or EMS related.

- Spokane Indian Reservation – BIA police in Wellpinit

A.1.f. Evaluating Communications System Providers & Dispatch Activities (The Regional Advisory Committee, consisting of representatives of all EMS regions statewide have prepared and are using the following survey to provide consistent information on EMD training.) Please see Table A.

TABLE A.
EVALUATION OF COMMUNIATOIN SYSTEM PROVIDERS & DISPATCH ACTIVITIES

		Adams	Asotin	Ferry
	Survey Questions	***Adams County 911***	***Asotin County 911***	***Ferry County 911***
1	Citizen Access	None	E-011	E-911
2	Consolidated Centers	Yes, fire, law and EMS	Yes, city, county, fire, EMS & jail	Yes, fire, EMS & police
3	Number of Employees	10	10 cross-trained	9
4	Number of Employees Not Trained	*None are EMD trained*	8 are not EMD trained	7
5	Kinds of Training	Criminal Justice Required Training	CJT, Call Taker I and some II	3-day initial when recertifications are due
6	Frequency of Training	40 hours per year	Required only	N/A
7	On-going Training & Certification	No EMD Training or Certification	None	Yes, NAEMD
8	Kinds of Protocols	No EMD Protocols	Internal protocols	Medical Priority Protocols
9	Medical Director Involvement	None	None	None to date. New MPD will be visiting in 7/2001.
10	Dispatch Prioritizing	None - agency is too small.	medical, fire, law no EMS	None to date. New MPD will be visiting in 7/2001.
11	Bystander Care	None	None	None to date. New MPD will be visiting in 7/2001.
12	Pre-arrival Instructions	None	None	Yes
13	Quality Assurance	None	None	No, but plan to start. Currently through county EMS council.

		Garfield County	Lincoln County	Pend Oreille County
	Survey Questions	***Sheriff's Department***	***Sheriff's Department***	***Pend Oreille 911***
1	Citizen Access	E-911	E-911	E-911
2	Consolidated Centers	Fire, Police, EMS all consolidated	Yes, fire, law and EMS	Yes
3	Number of Employees	8	9	Currently 9. Generally have 11
4	Number of Employees Not Trained	1 new employee soon-to-be trained	3	All 9 are EMD trained
5	Kinds of Training	Various	Various	Various
6	Frequency of Training	As needed and/or required	As needed and/or required	Monthly
7	On-going Training & Certification	Yes, NAED	Yes, NAED	Yes, NAEMD
8	Kinds of Protocols	Medical Priorities	Medical Priorities	Medical Priorities
9	Medical Director Involvement	No	No	Yes. Old Medical Director gone. New one coming soon.
10	Dispatch Prioritizing	Too small for dispatch prioritizing	No	No
11	Bystander Care	Yes	Yes	Yes
12	Pre-arrival Instructions	As needed	Yes, if caller stays on the line	Yes
13	Quality Assurance	Yes	Yes	Yes, Internal

	Spokane		
Survey Questions	***Spokane County 911***	***AMR***	***Fairchild***
Citizen Access	E-911	999 Fire	Fire, EMS as dispatched by base police
Consolidated Centers	Yes	No	Yes
Number of Employees	18	12	4
Number of Employees Not Trained	0	5	3
Kinds of Training	Various	Various	Various
Frequency of Training	Weekly	Monthly/Yr.	Monthly Review
On-going Training & Certification	Yes	Nat'l Registry	No
Kinds of Protocols	EMD, Pro-QA, SOPs	Medical Priorities	Encouraged but not required
Medical Director Involvement	Yes - Part time	No	N/A
Dispatch Prioritizing	PRO-QA suggested responses	Alpha, Bravo	Based upon level of injury. Dispatchers are EMT-B Trained
Bystander Care	Yes	Yes	No
Pre-arrival Instructions	Yes	Yes	Yes
Quality Assurance	Yes	Yes	Yes

	Stevens County		**Whitman County**
Survey Questions	***Stevens 911***	***Spo Indian Res.***	***Whitcom***
Citizen Access	E-911	911	Yes, September 1, 2001
Consolidated Centers	Yes	No	Yes
Number of Employees	Normally 14 - Currently 11	5	14
Number of Employees Not Trained	2 are currently in training	5	0
Kinds of Training	Required, single subject	N/A	Various
Frequency of Training	Weekly, Monthly, Annually as needed	N/A	2-years
On-going Training & Certification	Yes, NAEMD & Criminal Justice Training	BIA Requirements	Yes
Kinds of Protocols	Medical Priorities	BIA Law Enforcement	Medical Priorities
Medical Director Involvement	Yes	Police does Fire and Amb.	No
Dispatch Prioritizing	Concept of Alpha Bravo used but not words	N/A	Alpha, Bravo
Bystander Care	Yes, NAEMD	No	No
Pre-arrival Instructions	Yes	No	Yes
Quality Assurance	Yes - Now using NAEMD	No	Yes, sometimes but it is not yet official.

A. 2. STRENGTHS AND WEAKNESSES: Discuss the strengths and weaknesses of the current system to include an assessment of additional needs within the region.

Communications Deficiencies

The East Region's Trauma Plan (approved 3/18/99) identified deficiencies in the communications systems that were submitted to the Regional council prior to June 30, 1997. In order to provide current information, project coordinators were contacted in order to determine if those needs are still legitimate. The projects that remain viable are listed below. Projects which would allow interfacing between the HEAR and MEDCOM systems are not viable unless prehospital providers upgrade their radios to this frequency. Additionally, communications projects submitted to the Regional Council in December of 1998 are also listed below.

- South Spokane County has identified a need for a paging extender. This project would affect four EMS districts and one ambulance service in Spokane County. Projected Cost = $5,880.40.

- Whitman County has identified a need for a voting receiver in Tekeo. This project would affect 4 EMS districts and 1 ambulance service in Spokane County. Projected Cost = $6,264.

- Spokane County has identified a need for Fire/EMS Voter Receiver, which would affect one EMS district in the Spokane County suburbs. Projected Cost = $6,000.

- Spokane County has also identified a need for PL71 In Cab Communications that would affect one EMS district in Spokane County. Projected Cost = $2,500.

- Inadequate accessibility in some areas of Lincoln County due to geographic terrain has been identified. The current system needs enhancement in order for prehospital providers to access medical control authority. On-scene communications between prehospital providers and designated hospitals are spotty.

  A prime location for a crossband repeater is available with power, space, and tower at no cost and is located safely in a central location within an old missile control bunker. A crossband repeater would help Lincoln County make essential connection with the trauma centers and prehospital personnel. The crossband repeater would be installed at Mielke's Ridge in Lincoln County. Mielke's Ridge has been examined for area services, site space, power grid and specially applications. It is an acceptable location for a crossband repeater. It should also be noted that the crossbanding would allow interface between HEAR and MEDCOM (the Washington State backbone system). Cost of these improvements is estimated at $4,800.

- Some prehospital providers in Whitman County find it difficult to communicate with medical control due to terrain and distance. Hospitals are too far away to communicate by radio with prehospital providers. Unless a repeater is placed somewhere such as Moscow Mountain, the purchase of cell phones and portable radios would allow communications necessary. Estimated cost of this project is $5,100.

It is likely that there are other areas of the region where communications are less than satisfactory, however they have not been identified as of this writing.

3. Demographics:

a. Identify specific demographics of the region that impact communications system development in the region.
b. Consider looking at other data elements such as total population of the region, total numbers of licensed drivers/licensed vehicles in the region and miles of roads in the region.

- Demographics are identified in Needs and Distribution of Services reports in the Verified Aid and Ambulance Section of this chapter.

4.GOALS, OBJECTIVES, STRATEGIES AND PROJECTED COSTS: List the Regional EMS/TC system's goals, objectives, strategies and projected costs to improve the communications system to build on the strengths and mitigate the weaknesses.

GOAL I: Have well educated Emergency Medical Dispatchers region-wide.

A. Encourage continuity in all communications centers region-wide

- The Regional council will host at least one EMD class in the spring of FY 02 and/or FY 03 according to need.
  - **Projected cost** of each three-day initial EMD class = $4,250.
- At least two one-day protocol update classes will be held in the spring of FY 02 and will scheduled as needed in FY 03.
  - **Projected cost** of each update class = $1,000

B. MEDICAL DIRECTION OF PREHOSPITAL PROVIDERS: 1) *Discuss the system of off-line and on-line medical direction; 2) Discuss strengths and weaknesses of the current system; 3) List the Regional EMS/TC system's goals, objectives, strategies and projected costs to improve the system.*

Medical Control means Medical Program Director (MPD) authority to direct the medical care provided by all certified EMS/TC personnel involved in patient care in the prehospital EMS/TC system.

Off-Line Medical Control

Off-line Medical Control is defined in each county's protocols. "Prehospital patient care protocols" are the written procedures adopted by the MPD under RCW 18.73.030(13) and 70.168.015(26) that direct the out-of hospital emergency care of the emergency patient that includes the trauma care patient. These protocols are related only to delivery and documentation of direct patient treatment.

In the East Region some MPDs have developed specific patient care protocols for EMS personnel to follow with regard to patient care. Others have implemented the protocols developed by the Department of Health. At the direction of the County Medical Program Director, prehospital providers implement these protocols in situations where communications are not available with on-line medical control. Prehospital providers are able to care for the patient until on-line medical control can be reached and directions given to the EMS provider regarding the care of the patient.

Strengths of Off-Line Medical Control

- Written protocols allow the Medical Program Director the opportunity to provide prehospital EMS providers the means for patient treatment when direct contact with medical control is unavailable.
- All DOH approved protocols are listed on their web site. Since most people have access to a computer, this ensures that EMS providers have access to the current approved protocols.
- All DOH approved Regional Patient Care Procedures and County Operating Procedures are currently listed on the Department's WEB site. Since most people have access to a computer, this ensures that EMS providers are updated on the current approved procedures.
- The Regional Council currently contracts with the Inland Empire Training Council to provide training to prehospital providers on regional Patient Care Procedures and intends to contract with them to provide instruction on approved County Operating Procedures.

Weaknesses of Off-Line Medical Control: *This should address the weaknesses in medical direction of Prehospital providers.*

- The weakness is that not all providers have access to all protocols, COPs and PCPs in a timely manner. The solution is to find methods to ensure that all providers have timely access to all directives at all levels. One potential solution may be to have all directives available on the Internet, either through the DOH web site, the regional web site, or at the county and local level.
- A second weakness is the difference in protocols/COPs/PCPs across county and regional lines. The solution would be to find common ground with the MPDs to allow for providers that work at the edge of their service area or outside of their service areas.

GOALS, OBJECTIVES, STRATEGIES AND PROJECTED COSTS: *This section should address how the direction of prehospital providers will be improved using goals, objectives, strategies and projected costs.*

Off-Line Medical Control Goals, Objectives and Strategies

Goal 1: Discuss a partnership with the Department of Health and the region for development of a web site to provide DOH approved protocols, COPs and PCPs access to all prehospital personnel in the East Region.

A. Prehospital personnel impacted by a change will have access to that change within five calendar days.

- Bring together the information services personnel from the region and the Department of Health to discuss opportunities to place policies on a web site.
- Bring together the county MPDs from the East Region to discuss the possibility of sharing protocols with the Webmaster.

Projected Costs are to be determined by the IS personnel and managers.

Goal 2: Provide a uniform set of protocols and COPs for people working across traditional boundaries.

A. Provide consistent care and common medical direction for providers working across jurisdictional boundaries.

- Bring together MPDs, county council chairs, and other interested parties to design protocols and COPs that will work within and across jurisdictional boundaries.
- Work with the Department of Health to establish a breakout session to discuss protocols and COPs with MPDs at one of the state MPD meetings.
- If unable to coordinate this meeting at the state MPD meeting, then host a regional MPD meeting to continue the work.

Projected Costs: The costs would equal current costs of protocol and COP development and revision. There will be no additional costs above and beyond that. Specific additional costs would be limited to combined meetings of stake holders and staff to support development after which continuing costs would decline as protocols and COPs could be developed from a central point reducing costs.

On-Line Medical Control

On-line medical control may be authorized by the Medical Program Director and may be any place prehospital providers are instructed to call for on-line medical control. In many cases, it is a health care facility that has received trauma designation. On-line medical control is where a prehospital provider may speak directly with a physician delegate regarding patient care and delivery. Medical Program Directors may delegate responsibility to other physicians in accordance with WAC 246-976-920.

In the East Region prehospital providers are instructed to contract on-line medical control (at the highest level trauma designated facility that can be reached within 30 minutes) for direction on how to treat a trauma patient. Medical control is generally contacted by radio on the HEAR system, however there are instances when cell phones are used to contact medical control. Rural prehospital providers use the means for contacting the designated facility that works best for them in their specific circumstances.

Strengths of On-Line Medical Control

- On-line medical control allows prehospital providers to talk directly to medical control regarding the care of the EMS and trauma patient.

Weaknesses of On-Line Medical Control

- The primary weakness when using on-line medical control is the inability of field providers to make contact with the receiving hospital. The problem is a lack of range of repeaters and/or cell sites to ensure continuous communications with the base stations.

- A secondary weakness is ensuring that the staff at the base station is trained and knowledgeable in Prehospital Patient Care protocols, COPs and PCPs. It is not uncommon to have staff answering the base station radio that have very little familiarity with prehospital protocols, County Operating Procedures and Regional Patient Care Procedures.

GOALS, OBJECTIVES, STRATEGIES AND PROJECTED COSTS: *This section should address how the direction of prehospital providers will be improved using goals, objectives, strategies and projected costs.*

On-line Medical Control Goals, Objectives and Strategies

GOAL 1: Identify opportunities to improve radio and/or cellular communications with medical control within the East Region.

A. Ensure that EMS providers region-wide can make contact with base stations 98% of the time in varied weather circumstances.

- Work with communications specialists familiar with the East Region communications plan to identify under utilization of equipment or services.

- In collaboration with the Communications and Prehospital & Transportation Committees, identify shortfalls in equipment and other resources by analysis of the current communication system within the East Region and seek new technology to repair shortfalls.

- Seek funding resources to address shortfalls found in the evaluation process.

Goal 2: To have EMS personnel make contact with qualified, trained personnel at the base station.

A. EMS personnel will have access to staff trained in protocols, COPs and PCPs 100% of the time at base receiving stations.

- Provide information and training to a select staff at all base station operations.

- MPDs or their delegates and other available county prehospital staff will provide initial training of core staff through county EMS/TC councils.

- Core staff that has been trained can then provide continuing education and in service opportunities within the facility for all personnel that would be assigned the responsibility of operating the base station.

Projected Costs: Development of a training outline, copying of applicable protocols and packaging and train the trainer costs. All are dependent upon travel, distance, time involved, etc.

C.1. CURRENT STATUS: *Describe available resources, configurations, staffing, and service levels of current prehospital provider services.*

A. Overview

Many rural counties who have tried to meet ALS specifications find that they are unable to keep their EMS/TC personnel certified due to the lack of ALS response volume. Some agencies may have ALS personnel available for runs, however are unable to maintain ALS status, thereby obtaining licensing as a BLS or ILS service. In areas where EMS/TC personnel is 100% volunteer, it is difficult to provide consistency in ALS trained personnel who would be available to respond.

Lack of funding, not only for the rural areas, but for the Regional Council is one of the major problems preventing rural areas from participating in Intermediate and/or Advanced Life Support programs. During FY 01 the Regional Council provided two ILS classes to rural prehospital providers, one class was held in Whitman County and the other in Lincoln County. In the spring of 2001 the East Region applied for outside grant funds to provide 4 scholarships to the Spokane Community College Paramedic class that starts in September of 2001. The council has also applied for outside funds to provide 2 ILS classes during FY 02. Monetary awards will be announced in August 2001.

Clarkston Fire Department maintains an ILS aid vehicle service, however is able to provide ALS patient care until the Lewiston Fire Department (transport) arrives on the scene.

Paramedic courses offered at Spokane Community College are available every year with courses in September. Prerequisites for this class are offered during summer quarter. This fall 4 positions have been awarded to East Region prehospital providers.

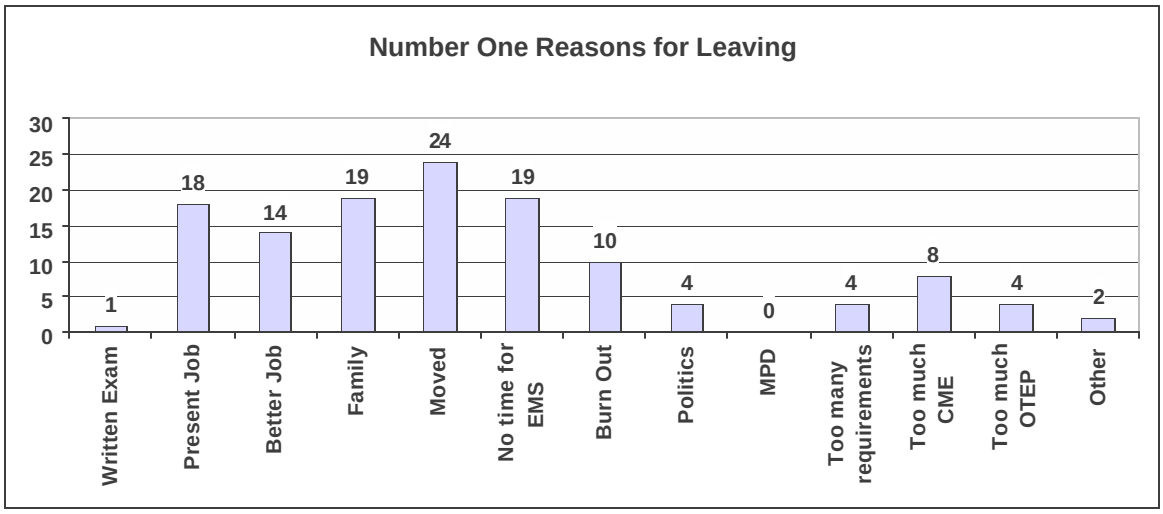
Although a BLS and ALS tiered response system is not available in each county of the region, a tiered response system does exist. Many of the rural counties, such as Pend Oreille County, may have a non-transport service (first responder) dispatched to the scene first, and the transport service dispatched second, and may also have dispatched air transport service as well. Rural areas rely so heavily on the air transport service, that BLS response first and air transports second are considered a tiered response system within the region. If weather prohibits the use of airlift services, then the local EMS prehospital agency will transport the patient via ground vehicle to the closest appropriate facility. If a patient's condition requires transfer to a higher designated facility, the transfer will be accomplished using a ground or air service.

Retention and Retainability

Maintaining volunteer and career personnel remains an endless endeavor in the East Region. Our Regional Council, for example, has changed in individual membership many times during the past few years. As people leave the EMS system for a variety of reasons, it continues to be more and more difficult to find replacements.

The East Region has a significant problem with maintaining the number of prehospital providers in rural areas with the skills needed to provide optimal patient care consistent with state standards. This is due to attrition rates, geographic difficulties, and dependence on volunteers. With the reduction in staff supported education services, there is a need to increase funding for initial training, OTEP/CME activities, and evaluation of knowledge/skills that are provided at the "grass roots" level, region-wide.

The number of career and volunteer personnel in BLS services is low given the geographic area to be served. However, there are insufficient funds available to expand the number of paid career personnel in the rural and wilderness areas, requiring that the EMS and trauma system continue to rely on volunteer personnel. The Regional Council has determined that it can effectively improve the rural system of EMS and trauma care by increasing the skill level of those currently providing BLS services and reducing attrition rates.



Source: East Region Training Survey FY 01

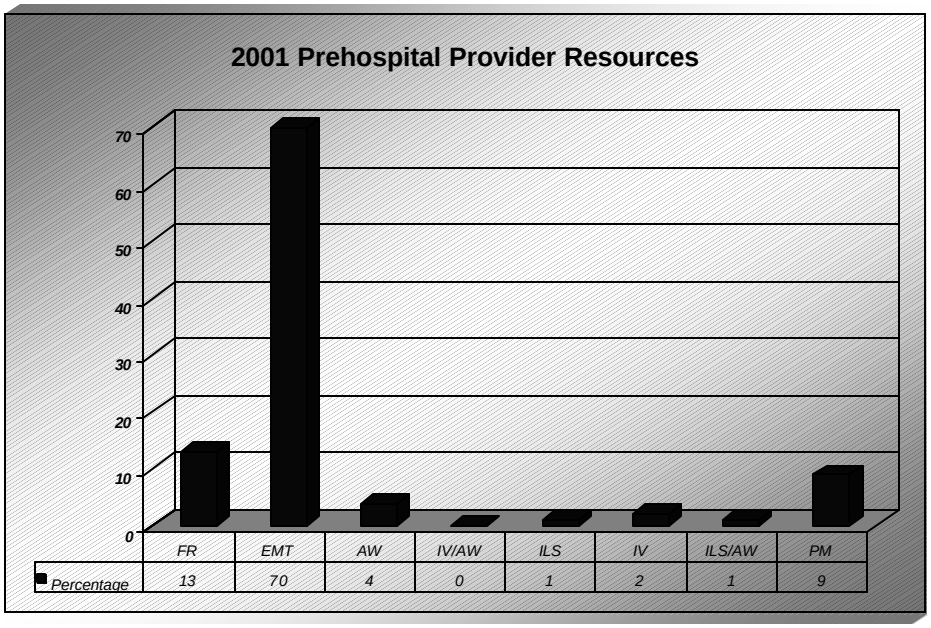
C.1.A. CURRENT EMS/TC PERSONNEL RESOURCES: *Identify the EMS and trauma care workforce resources available within the region, by county, to include all levels of prehospital personnel.*

The information listed in the table below shows the number and type of certification maintained by providers in each county of the region. The table also shows the percentage of career (paid) vs. volunteer providers by county. Since 1999 there has been a reduction of 50 EMS and trauma providers in the region. Information from the DOH, Licensing and Certification Section indicates an increase of 1% in career providers making the current percentage of career providers 38% and volunteer 62%.

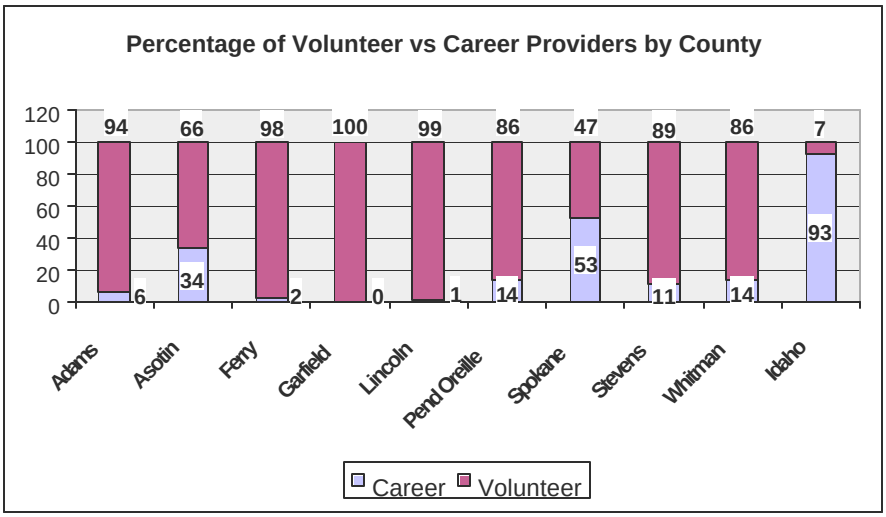
COUNTY	FR	EMT	IV	AW	IV/AW	ILS	ILS/AW	PM	2001 TOTALS	1999 TOTALS	2001 % Career	2001 % Volunteer
Adams	1	53	0	0	0	0	0	0	**54**	**66**	**6**	**94**
Asotin	0	27	0	0	0	0	0	6	**35**	**42**	**34**	**66**
Ferry	3	49	0	0	0	0	2	0	**54**	**37**	**2**	**98**
Garfield	5	15	0	0	1	0	0	0	**21**	**22**	**0**	**100**
Lincoln	18	85	7	0	0	10	0	0	**120**	**120**	**1**	**99**
Pend Oreille	22	61	6	0	2	0	2	5	**104**	**104**	**14**	**86**
Spokane	144	1019	29	0	3	18	10	156	**1379**	**1374**	**53**	**47**
Stevens	40	134	20	0	0	14	1	0	**209**	**234**	**11**	**89**
Whitman	66	160	9	0	5	5	9	8	**262**	**278**	**14**	**86**
Idaho	0	12	23	0	1	0	0	18	**54**	**65**	**93**	**7**
2001 Totals	**299**	**1615**	**94**	**0**	**14**	**47**	**30**	**193**	**2292**	**2342**	**38**	**62**

*Source: DOH, Licensing and Certification Section, 5/01

The chart below clarifies the percentage and type of certified providers in the East Region.



This next chart may be the most interesting of those in this section. It identifies the percentage of career vs. volunteer EMS providers region-wide. You will notice that Garfield County does not have ANY career providers but operates totally with volunteers where Pend Oreille County boasts 1% of its total providers are career. As expected, Spokane County followed by Asotin County have the highest percentages of career providers in the region.

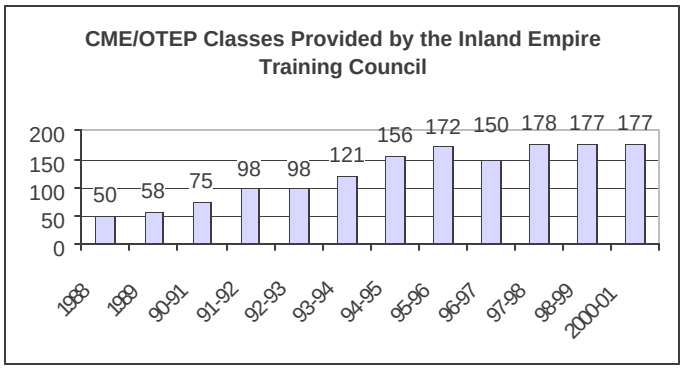


C.1.B. PREHOSPITAL TRAINING RESOURCES – *Identify available training resources for all levels of prehospital EMS/TC personnel.*

Community Based Education Program - Inland Empire EMS Training Council (Mobile Training Van – MTV)

The Inland Empire EMS Training Council, here after referred to as the Training Council, has been in existence for several years and operates the Mobile Training Van (MTV) that provides training throughout the East Region. This program enjoys an outstanding reputation throughout the nine counties. Because training goes to the rural areas, EMS/TC providers are able to keep up with required OTEP/CME and are able to take advantage of other courses provided by the MTV. It is the desire of the Regional Council to continue providing OTEP/CME training to paid/volunteer EMS/TC providers in such a manner as to provide convenience and accessibility.

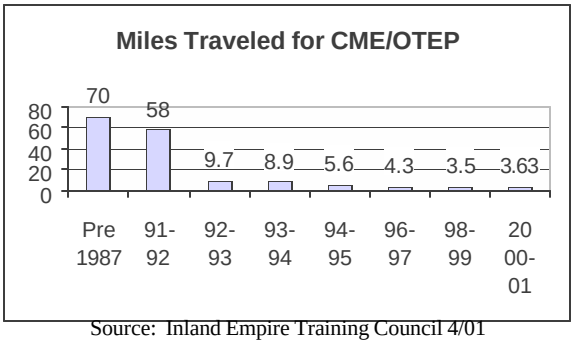
OTEP/CME: The main focus of the Mobile Training Van is to provide Community Based Continuing Medical Education, with the rural BLS volunteer provider being the target audience. Below is a chart showing the number of CME classes provided by the Inland Empire Training Council since 1988.



Source: Inland Empire Training Council 4/01

Mileage

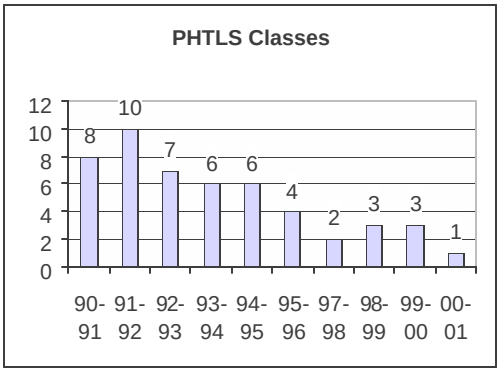
The goal of community-based education is to reduce the number of miles that prehospital care providers travel in order to receive required OTEP/CME and thus decrease attrition. The Department of Health requires tracking of one-way miles traveled to education in order to evaluate the effectiveness of the program. The number of miles traveled by Eastern Washington providers has dramatically decreased since the initiation of the Mobile Training Van. FY 99 comes in at a record low of 3.5 miles travel to get to CME/OTEP classes with a slight increase of .13 miles for 2000-01 at 3.63 miles.



Source: Inland Empire Training Council 4/01

PHTLS

In response to the Department of Health requirement for trauma training, the East Region and the Training Council has provided Pre-hospital Trauma Life Support classes throughout the East Region. While this has been an extremely beneficial program most of its elements are covered in the new EMT-B curriculum which also satisfies the DOH requirements. Thus, you will notice a great decline in the number of PHTLS classes being offered in the region. While the East Region considered the possibility of making PHTLS a self-supporting class, and still may in the future, volunteer agencies have indicated that funding is not available for them to provide the class registration fee. The Regional Council has received a grant award for FY 02 for a PHTLS Refresher course.



Source: Inland Empire Training Council 4/01

Pediatric

The State of Washington emphasized its concerns regarding pediatric pre-hospital care when they provided several EMS-C instructor courses early in 1988. The Training Council has utilized these instructors to provide three and six hour EMS-C modules through the Mobile Training Van. The National Association of EMTs has modified the PHTLS curriculum to allow for an optional pediatric section. Pediatric experience has been included in each PHTLS course. Also, in accordance with DOH guidelines, a pediatric component is included in each mandatory assessment and patient packaging class. The Regional Council has applied for outside grant funding in order to provide 6 BLS Pediatric Education for Prehospital Provider courses during FY 02. The intent is to try to add the ALS Pediatric Education for Prehospital Provider course to the EMS Conference held in either 2002 or 2003.

The East Region encourages participation in the DOH sponsored Pediatric Pre-hospital Education & Training workgroup. Both the chair of the regions Training and Education Committee and the director of the EMS Training Council are actively involved in this productive committee. They are currently developing pediatric instructor resources and serving as advisors to the Pediatric TAC.

The American Academy of Pediatrics has rolled out a new pediatric course designed specifically for pre-hospital providers (PEPP). This program has received excellent reviews and would be an appropriate avenue to upgrade East Region pediatric education. The director of the EMS Training Council recently received the credentials to coordinate this course and train instructors. Funding is currently being sought to provide this program throughout our area.

Pediatric Classes Held In the East Region

1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
8	27	21	26	22	25	22	20	23	23	25	28	30

Instructor Support

In addition to providing education for the pre-hospital EMS/TC provider, the Training Council offers instructor education to increase the quality and availability of pre-hospital educators. In order to be cost effective, instructor education is offered jointly to the East/North Central Region instructors. Four BLS evaluator workshops were conducted to support of the OTEP programs region-wide. A PHTLS instructor renewal class was conducted to upgrade our trauma course instructor pool. This year the American Heart Association revised guidelines for CPR instructors and 6 classes have been offered to update instructors in new resuscitation teaching techniques.

Special Projects

Since the infrastructure of the Training Council is established, several special projects have been completed at no additional cost. The PTL study enabled the Department of Health to document that BLS personnel could safely utilize this airway adjunct. Submitting and obtaining CERP credits has allowed nurses to receive approved trauma training through PHTLS. Applying for, and receiving grant funds for interactive video disc training has increased the quality and diversity of education offered through the Mobile Training Unit. Implementation of OTEP programs has streamlined the certification process for pre-hospital providers. The Training Council has established a cooperative relationship with Injury Prevention and Public Education by supporting their much-needed projects.

A new pediatric course was introduced by the American Academy of Pediatrics in 2000. The director of the Training Council has become a course coordinator and instructor trainer for this program so that it can be implemented in the East Region when funding becomes available.

At the request of the Regional Council, the Training Council has established an inventory of text/work books that are available for initial EMT/FR courses at an at-cost basis. In 1999-2000 the Training Council sold approximately $20,500 worth of books.

First Responder & EMT-B Initial Training

Although the Council continues to apply for outside funding to help counties with First Responder and EMMT-B training, funding has not been forthcoming. Some agencies are applying for training funds through the Prehospital Needs Grant program through the DOH. In some area, county EMS/TC councils provide the cost of supplies and a stipend to instructors, however a relatively high tuition cost is still charged to volunteers.

Implementation/Funding

It is the intention of the East Region to continue to coordinate and work with the Inland Empire EMS Training Council to provide necessary training throughout the region. The Regional Council has charged the Training and Education Committee with the responsibility of reviewing courses being offered by the Mobile Training Van and to determine what new courses should be added to the curriculum in the future. Although the cost of a high quality-training program reflects many things, the ultimate product delivered is education.

In 1992, prior to the implementation of our newsletter, 1455 students participated in training at a cost of $17.76 per student hour. Since the newsletter has been implemented a dramatic increase in student participation has occurred and will likely exceed 3,000 in 2000/2001. Current cost per student hour has declined to $10.54.

The Regional Council received $25,000 grant funds for FY 02 and will be used for one Paramedic scholarship to the 9/2001 Paramedic class, 6 PEPP classes, one PHTLS refresher course and 2 ILS classes.

Paramedic Training

The 2001 Paramedic class being held at Spokane Community College will provide 4 seats for rural prehospital providers wishing to increase their skills level as well as the agency's verified status. The class will begin in September 2001 with pre-requisites to be taken during the summer quarter. At this time, there are very few rural agencies that can support ALS aid or ambulance service, either financially or with personnel. The Regional Council is applying for outside grant funding in order to provide scholarships for the providers wishing to take the Paramedic course in 2001.

ILS Training

Support of the ILS curriculum and encouragement of this skill level in the rural area has long been a goal of the East Region. Two ILS classes (120 hours each) were funded by the East Region for rural areas. The Lincoln County class graduated 20 ILS technicians in December of 2000. The Whitman County class, in the spring of 2001 has 15 successful students complete the curriculum.

C.1.C. PRIORITIZING AND CONDUCTING PREHOSPITAL TRAINING – *Discuss the need for training to maintain existing level of personnel and to add needed personnel to the system, including a discussion of strategies for prioritizing and securing needed prehospital personnel training.*

Need for Training

CME and OTEP are provided annually and funded through the contractual agreement between the Regional Council and the DOH. The Training & Education Committee has identified additional training needs through a training survey (see addendum for survey report). Additional training needs for FY 02 and probably FY 03 have been identified as follows: 2 ILS courses; 4 paramedic scholarships; 6 BLS PEPP courses; 2 PHTLS Provider and 1 Refresher course; and 12 Initial Basic Training (FR & EMT) classes.
Prioritization List & Out of Pocket Costs

1. The major priority for training regionwide is CME and OTEP. In the past, the Regional Council has committed $101,780 annually to ensure this training is accomplished. (Biennium costs = $203,560)
2. Intermediate Life Support – Projected cost of 2 classes in 2002 is $15,000. (Biennium cost = $30,000)
3. Paramedic Training – Projected costs for four scholarships in 2002 is $8,800. (Biennium costs = $17,600)
4. Pediatric Education for Prehospital Providers (PEPP) – Projected costs for 6 BLS PEPP classes during 2002 is $6,000. Projected cost for ALS PEPP is $2,000 each class.
5. PHTLS – Projected costs for 2 Provider classes and 1 refresher class is $12,000 (biennium costs = $24,000)
6. 12 Initial BLS Provider Courses – Projected costs for 2001 = $38,400 (biennium costs $76,800)

Strategies For Prioritizing And Securing Training

The Training & Education Committee prioritizes the training needs of the region in the spring of each fiscal year. The committee uses the results of the needs assessment to determine what the additional training needs are. If there are additional needs, and funding is not available through a contractual agreement with the DOH, outside funding is sought to cover costs.

The Regional Council contracts with the Inland Empire Training Council to provide CME, OTEP and PHTLS throughout the fiscal year. If funding is available, the Regional Council may also contract with the Training Council to provide special skills classes such as ILS training or PEPP.

The County EMS/TC councils sponsor initial FR and EMT training as well as some special skills classes. Students pay a registration fee for the class and if the county has funding available, instructors receive a stipend. In most counties instructors are not reimbursed for teaching a class. If funding becomes available, the Regional Council will reimburse the county council for the expenses involved in sponsoring the training.

C.1.D. Additional Public Safety Personnel Role and Availability - *Discuss the need for training to maintain existing level of personnel and to add needed personnel to the system, including discussion of strategies for prioritizing and securing needed prehospital personnel training.*

Public safety personnel attend the EMT-Basic courses offered in the East Region on a routine basis. EMS and trauma care providers work hand in hand with law enforcement, search and rescue and also utilize military resources as it is appropriate. Other entities involved in public safety as it relates to the EMS and trauma system are: Washington State Patrol, Sheriff's Departments, Fairchild AFB, Air National Guard, Emergency Management, civil air patrol, and other military squadrons at Fairchild AFB, the Army Guard & Reserves and the Reserve Unit out of Camp Murray.

The Department of Defense personnel were in Spokane on May 3-12, 2000 to train and exercise our law enforcement, fire, mental health, public health, EMS, hospital, public works, government, medical examiner, and other response personnel in terrorism mitigation, planning, response and recovery efforts.

On May 3- 11th, approximately 250 personnel received training in Weapons of Mass Destruction; Responder awareness, Responder Operations, Incident Command, HazMat, EMS Technician and hospital Provider courses.

On May 12, 2000, over 100 community leaders, Government, law enforcement, fire, EMS, public works, hospital, medical program director, medical examiner, public health, mental health, National Guard, etc. participated in a Chemical Weapons of Mass Destruction Exercise. The 10th Civil Support Team from the Washington Army National Guard, Camp Murray, Washington was here to participate and provide guidance on how to mobilize their assets. An after action review from the Department of Defense is available upon request from the office of Spokane County Emergency Management.

On May 12, 2001 a region-wide exercise in biological warfare was held in Spokane. An after-action review has been performed on the exercise. Additional information is available upon request.

C.2. STRENGTHS AND WEAKNESSES - *Discuss the strengths and weaknesses of these programs to include an assessment of additional personnel and training needs within the region.*

Identified Weaknesses

- OTEP and community-based training have helped significantly, but travel and the time involved away from business and family remain economically and socially expensive for the volunteer provider. With these factors, there remains a high level of burnout among pre-hospital personnel and quality of care is potentially threatened.

- Spokane Community College is currently the only college in the East Region offering an EMT course curriculum. The cost of EMT and FR courses is borne by the sponsoring organization or in many rural areas, by the individual volunteer. Cost per class is $175-250.

- There is a lack of qualified instructors. This and other factors add to the difficulty in increasing the number of trained personnel at all levels, as well as maintaining their certifications.

A. Many ALS courses recommend that instructors be physicians, specifically surgeons, who are not readily available in urban areas, let alone rural areas.

B. There is a lack of support funding for instructors, particularly in rural areas.

C. Geographic configuration of the region with long distances and hazardous winter travel for instructors and students is a major stumbling block.

As long as our pre-hospital providers are made up of 68% volunteers, it will be a constant struggle to have people step forward, receive training, stay around for three to six years, and not get burned out. The East Region remains strongly committed to overcoming the difficulties of recruiting, training, maintaining, and retaining rural EMS volunteers. Please refer to the attrition chart in this section.

Identified Strengths

The greatest strength of the East Region is the Inland Empire Training Council. The East Region contracts with the Inland Empire Training Council, which uses the Mobile Training Van (MTV) to provide CME and OTEP to rural providers throughout the region. This resource has reduced the necessary miles providers must travel for Continuing Education and leaves resources available to respond to EMS and trauma calls.

C.3. DEMOGRAPHICS - *Identify specific demographics of the region that may drive the expansion of the existing prehospital personnel and training personnel and training such as population by age and gender.*

Demographics have been identified in the Needs and Distribution of Services section of this plan.

C.4. GOALS, OBJECTS, STRATEGIES AND PROJECTED COSTS

The following goals and objectives were taken from the 2001-02 East Region Trauma Plan, and have been updated by the East Region's Training & Education Committee.

GOAL I: Prehospital EMS/TC Training Should Be Provided Region-Wide.

A. Pursue The Development of ILS and Paramedic Training and Operations Regionwide

1. Address and negotiate inter-agency issues concerning ILS and Paramedic training.

2. Pursue future funding for ILS and Paramedic training in the rural areas of the region.

   - Outside funding for 1 paramedic scholarship was secured for FY 02 by the Training & Education Committee.

   - Grant awards will be announced in August 2001.

B. Continue to Improve The Mobile Training Van Service

1. Pursue grant revenue to cover increase in program costs.

2. Utilize surveys to continue monitoring effectiveness (See Training Survey in Addendum Section)

3. Improve administrative efficiencies.

C. Encourage And Assist Local Councils To Provide Initial Training For Certification Of EMT/FRs To Offset

Attrition Rates And Increase The Number Of Personnel Certified.

1. Support and help coordinate initial training of EMT/FRs.

   - The Training Committee has applied for outside grant funds to help defray costs to county EMS/TC councils in providing initial BLS training for certification.

   Projected Costs

12 Initial BLS Provider Courses @ 16 students x $200	$ 38,400
12 Initial BLS Provider Courses @ 120 hours x 16 students x $15 volunteer in-kind	$345,600
Projected Cost FY02	**$384,000**
Biennium Costs	**$768,000**

   Note: Funding was not received.

D. Ensure That Education And Training Programs Reflect Recent And Upcoming Regulatory And Curriculum Changes.

1. Support and monitor WAC revision process through the public hearing and workshop process.

2. Assist DOH with implementation of new WAC changes in regional education programs.

3. Continue to update and monitor continuing education classes to ensure compliance with current and future DOH approved curriculum changes.

   - The Training Committee will, as a part of the contract process, work directly with the Inland Empire Training Council to ensure that all continuing education classes are compliant with DOH approved curriculum changes.

     - No projected cost involved.

4. Maintain close association and participation with DOH advisory committees including the Education Committee, the Licensing and Certification Committee, and MPD workshops.

   - The Regional Council will have at least one representative to the Education Committee.

   - The Regional Council has members already serving on the Licensing & Certification Committee, representing other agencies. They provide necessary information back to the council without duplicating travel requirements.

   - If possible, staff will attend MPD workshops. MPDs will also be encouraged to attend workshops via the usual communications method.

E. Increase The Number Of Qualified ALS/BLS Instructors

1. Support instructor education through representation on the state Education TAC.

2. Encourage physicians, surgeons, and EMTs to become more involved in ALS/BLS training within the East Region

F. Support Existing Programs And Conduct Additional Training Programs To Expand BLS Capabilities Throughout The Region

1. Continue to support prehospital OTEP/CME training region-wide.

   - This will be accomplished through the region's contract with the Inland Empire Training Council.

2. Statistically monitor the decrease in attrition through the effectiveness of OTEP.

3. Expand training programs to increase the number of EMTs with ILS skills. See D.3 above.

4. Sponsor an EMS provider conference in the spring of 2003 in Spokane, WA.

   - Work in collaboration with the North Central Region's Conference Planning Committee during FY 02 in order to glean knowledge on how to put together a conference.

   - The 2003 EMS conference in Spokane will be held tentatively on March 13-16th at the Convention Center.

     a. Projected Project Cost (Estimated) $10,000
     b. Projected In-kind Volunteer Costs Undeterminable

1. CURRENT STATUS

Inter-Regional Patient Care Procedures

The North Central, South Central and East Regions have, for a number of years, tried to address issues involving response areas and the prehospital services which it effects, through Patient Care Procedures. The negotiations were stopped a number of years ago due to legal issues affecting the prehospital services involved.

Many of the designated health care facilities have developed patient care procedures regarding transport of trauma patients, with other designated facilities and prehospital services, both inside and outside of the region.

Current Demand & Nature Of The System

Within the East Region, there are two very different forms of prehospital delivery systems. In the Spokane metropolitan area there is sufficient population and funds to support a tiered response system, including both BLS and ALS levels of service. In Whitman, Garfield and Asotin counties, a tiered response system exists due to Lewiston Fire Department, in Lewiston, Idaho, providing ALS transport. These services work well together; all calls receive a BLS response and for urgent and life threatening calls an ALS team is also dispatched. When needed, the patient is transported via air transport to the closest health care facility having the appropriate resources needed to treat that patient.

Many rural counties who have tried to meet ALS specifications find that they are unable to keep their EMS/TC personnel certified due to the lack of ALS response volume. Some agencies may have ALS personnel available for runs, however are unable to maintain ALS status, thereby obtaining licensing as a BLS or ILS service. In areas where EMS/TC personnel is 100% volunteer, it is difficult to provide consistency in ALS trained personnel who would be available to respond.

Lack of funding, not only for the rural areas, but for the Regional Council is one of the major problems preventing rural areas from participating in Intermediate and/or Advanced Life Support programs. During FY 96, the Regional Council was able to secure an outside grant that provided funding to the Clarkston Fire Department in Asotin County to train their personnel to the paramedic level.

Clarkston Fire Department still maintains a BLS aid vehicle service, however is able to provide ALS patient care until the Lewiston Fire Department (transport) arrives on the scene. The Regional Council has recently awarded Whitman County three positions in the Paramedic Program offered through Spokane Community College.

Paramedic courses offered at Spokane Community College (which in the past has contracted only with Spokane County) are generally available every other year with courses beginning on January 1st. In the past, rural EMS/TC providers had a difficult time being placed in this course since the college usually contracted with the Spokane prehospital agencies. In FY 96, the Regional Council began working closely with the Spokane County EMS/TC Council to determine whether or not there was a need for paramedics in the rural communities as well as in Spokane County. Consequently, Whitman County was awarded three positions in the 1997 Spokane Community College Paramedic class. At some time in the near future, Pullman Fire Services plans to become an ALS service.

In 1995, Spokane Community College participated in an outreach program that allowed the Clarkston Fire Department to train personnel as paramedics. This class was so successful that testing scores were generally higher than when taken at Spokane Community College.

Although a BLS and ALS tiered response system is not available in each county of the region, a tiered response system does exist. Many of the rural counties, such as Pend Oreille County, may have a non-transport service (first responder) dispatched to the scene first, and the transport service dispatched second, and may also have dispatched air transport service as well. Rural areas rely so heavily on the air transport service, that BLS response first and air transports second are considered a tiered response system within the region. If weather prohibits the use of airlift services, then the local EMS prehospital agency will transport the patient via ground vehicle to the closest appropriate facility. If a patient's condition requires transfer to a higher designated facility, the transfer will be accomplished using a ground or air service.

Today, the East Region has a total of 70 licensed prehospital services (2 in Idaho) that include 40 aid vehicle services and 29 ambulance services and 1 air ambulance services that provides coverage region-wide. The majority of the rural ambulance services are both first response and transport agencies. Several of them have a back-up vehicle to carry extrication and other specialized equipment.

In most parts of the region a true-tiered response system exists and is in operation. First response or aid vehicles are the first on-scene, to be followed by the ambulance for transportation; and in many cases transferred to either ALS air or ground ambulance at a rendezvous point. Where no first response is available the BLS ambulance service and the ALS air ambulance provide the tiered response.

Helicopters

The helicopter service in the East Region is Northwest MedStar. This service is based at Felts Field. Northwest Medstar has four rotary and two-fixed wing aircraft. This service continues to be effective in the air transport of the critical patient; both on-scene and interfacility.

There is another important factor to consider as efforts are made to improve the transportation system within the East Region. It has been emphasized that most of our EMS/TC personnel, in the rural areas, are trained to the BLS level. The medical personnel involved in air transportation are trained in all phases of prehospital patient care. Therefore, it may improve patient outcome if air transportation is used as much as possible, in an effort to meet the "Golden Hour", or at least improve the situation, as it exists today in many areas.

In an effort to provide guidelines for helicopter response, the Regional Council has developed and adopted Regional Patient Care Procedures for Helicopter Response. Counties have been asked to develop a County Operating Procedure, if their needs are more specific than those of the region.

Available Prehospital Resources

The chart below shows the current status of prehospital services within the East Region. Licensed and verified services by county are listed in the addendums.

County	Licensed Services		Verified Services		Air	Total	Total	Total
	Aid	Ambulance	Aid	Ambulance	Ambulance	Services	Licensed	Verified
Adams	0	2	0	2	0	2	2	2
Asotin	1	0	1	0	0	1	1	1
Ferry	0	2	0	2	0	2	2	2
Garfield	0	1	0	1	0	1	1	1
Lincoln	2	6	2	6*	0	8	8	8
Pend Oreille	7	3	7	3	0	10	10	10
Spokane	16	3	16	3	1	20	20	20
Stevens	3	3	3	3	0	6	6	6
Whitman	11	7	11	7	0	18	18	18
Regional Totals	**40**	**27**	**40**	**26**	**1**	**68**	**68**	**68**
Idaho	0	2	0	1	0	2	2	1
Grand Totals	**40**	**29**	**40**	**27**	**1**	**70**	**70**	**69**

Source: Licensing & Certification 6/01

*** Note: As of 12/01 all licensed agencies are verified. Creston Ambulance in Lincoln County was the last to become verified. The numbers have been changed to reflect this addition to verified ambulance services in the table above.**

A. PREHOSPITAL PLANNING AREAS (URBAN, SUBURBAN, RURAL, AND WILDERNESS)

Planning areas are identified in the Needs and Distribution (b) of this section. Each county has included their county planning areas in the Needs and Distribution of Services reports listed in the next section. The information in the chart below has been taken directly from the 1999 Data Book distributed by the Office of Financial Management. Some counties were able to include more recent information that what was available to the council at the time of this writing.

County	Land Area Square Mile	Total Population	Population Density Square Mile	Proportion Incorporated	Proportion Unincorporated
Adams	1925	15900	8.3	8061	7839
Asotin	635.9	20000	31.5	8055	11995
Ferry	2204	7300	3.3	1040	6260
Garfield	710.5	2400	3.4	1445	995
Lincoln	2311.2	10000	4.3	5749	4251
Pend Oreille	1400.5	11100	7.9	3080	8020
Spokane	1763.8	414500	235	212459	202041
Stevens	2478.3	38000	15.3	9446	28554
Whitman	2159.4	41900	19.4	35162	6738
Total	**15,588.4**	**561,100**	**367.1**	**28,4497**	**27,6693**

Source: 1999 Data Book

B. NEED AND DISTRIBUTION OF SERVICES – *Provide an assessment of the need for and distribution of services within the region as defined in RCW 70.168.100(1) (h). Discuss the current Regional process for determining need and distribution within each county in the region.*

Eight of the county EMS/TC Councils, in conjunction with the East Region's Prehospital & Transportation Committee, have been developing, reviewing and refining their Need and Distribution of Services (DOS), min/max recommendations for verified prehospital services and response area maps over the past two years. Each county has included planning area demographics in their reports.

The Regional Council, acting for Adams County (no active county council available) has worked with representatives of West Adams and East Adams to develop the Needs and Distribution of Services for the county. The Adams County document is currently in draft form, however the Regional Council's goal is to have the document completed and submitted to the DOH prior to the plan review in the fall of 2001.

Each county EMS/TC council was asked by the Regional Council to develop Needs a and Distribution of Services Report incorporating planning/response areas, current status, and future needs. Response area maps have been updated and are included as addendums. County Council Representatives then presented their reports to the Prehospital & Transportation Committee for review. Once the committee felt that the document was complete, recommendation for adoption was presented to the Regional Council. At this writing, all documents have been adopted except the Adams County Needs and Distribution of Services report.

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OVERVIEW

Adams County EMS is not unified into a dependable county council. Washtucna, Lind, Ritzville and Othello each have ambulance services. The ambulances are owned and operated by the two hospital districts. Adams County PHD #2 is known as East Adams Rural Hospital in Ritzville, which owns and operates four ambulances. They are responsible for Lind Ambulance Association, Washtucna Ambulance Association, and Ritzville Ambulance Association response areas. Othello Ambulance service is owned and operated by Othello Community Hospital and. operates in the Othello response area.

The lack of a functioning county EMS/TC council in Adams County is the reason for the difficulty with compliance on regional council correspondence and requested projects.

CURRENT DEMAND AND NATURE OF SYSTEM

West Adams County

Othello is located in the panhandle of Adams County. The service area is approximately 400 square miles with a population base of 5,500 within the city limits and seasonally 5,500 in the surrounding area. The Othello Ambulance service is bordered on two sides by two different counties, Franklin and Grant. The Othello Ambulance service is also bordered on two sides by two different EMS regions, the South Central Region and the North Central Region, however it is located in the East Region.

The Othello community has one high school, one Jr. high school and three grade schools. There are two medical clinics, one hospital with a helipad on the roof, as well as several large processing plants and several fabrication businesses. A volunteer fire department services both the city and county.

East Adams County

Ritzville, Lind, and Washtucna are located on the eastern half of Adams County. They service approximately 5000 people in this area. Ritzville and Lind are located along major highways; Lind along Highway 395 and Ritzville along I-90. East Adams Rural Hospital District #2 operates a clinic in each of these areas as well.

East Adams County has a number of schools located in Ritzville, Lind and Washtucna. They are as follows:

Ritzville	**Lind**	**Washtucna**
Ritzville Grade School	Lind Elementary	Washtucna School District
Ritzville High School	Lind High School	(all grades K-12 in one building)

GROWTH AREAS

Population growth is not anticipated in East Adams County. If there is any growth at all it will be growth in traffic relative to the two freeways going buy/through Ritzville.

GEORGRAPHIC VIEW

West Adams County Response Area

The Othello Ambulance response area consists of farmlands, rolling hills, vast areas of sagebrush and highways. Major highways in this area are 17, 24 and 26. Hunting, fishing, boating, and four-wheel terrain vehicles are the most popular outdoor recreations in this area. The weather is also a factor in our general area. During the winter months we experience drifting snow, ice storms and fog. In the spring and summer months we experience high winds and dust storms with zero visibility. The local highways in this area are two lanes with speed limits of 50 – 65 Mph. College students travel highway 26 and farmers who move farm machinery from one place to another can cause traffic congestion.

East Adams County Response Area

The Ritzville, Lind, and Washtucna response area consists mainly of farmland. We service I-90 and Highway 395. During the winter months we experience, icy road conditions, snowdrifts, and fog. During the spring and summer months we experience blowing dust and high winds.

COMMUNICATIONS

West Adams County

In the Othello area, cell phones, with 95% reliability, have made a big difference in some areas of the county, although some areas still lack communication abilities. Radio communications, with the improved technology, are somewhat better than they used to be. Their best coverage would be 85-95%.

East Adams County

In the Ritzville area the main method of communications is the cell phone. In Washtucna there are many places where the cell phones and radios will not transmit. In situations such as this, a relay with the local dispatch is set up. Northwest MedStar has recently donated to Washtucna Ambulance a GPS system to help with the problem of communication. Now, when Medstar personnel are dispatched and heading to the coordinates given, they can contact the ambulance directly to determine location.

CURRENT STATUS

West Adams County

Othello Ambulance is licensed and verified as a BLS ambulance service. There are currently 10 active EMT-Bs who are trained in comb-tube, auto defibrillation, IV Maintenance and receive OTEP through the agency. Othello Ambulance intends to remain a BLS ambulance service.

East Adams County

East Adams Rural Hospital maintains all ambulance services as BLS. There are currently 35 EMTs. Washtucna has 6 EMTs, Lind 7 EMTs, and Ritzville has 22 EMTs. Their goal is to continue to provide BLS service to cover these communities by recruiting and retaining EMTs. The EMTs remain current in training through the East Region Training Van. Medstar also performs in-services to the EMTs. East Adams has four ambulances, 2 ambulances are located in Ritzville. One ambulance each in Lind and Washtucna are housed at the fire stations.

FIRST RESPONSE

There is no first response in Adams County. The ambulances respond directly to all incidents. The fire departments respond only to traffic related incidents because they carry extrication equipment and the ambulances do no. Fire Fighters in Lind and Washtucna do serve as ambulance drivers when needed.

RESPONSE TIMES

West Adams County

- Tone to unit responding = 5 to 7 minutes
- Responding unit to arrival on scene = 2 to 15 minutes
- Two EMT-Bs respond on each unit per call. There have been times in the past, where we have, of necessity, had to use First Responders (ambulance personnel) as drivers.

- There are approximately 350 – 400 responses per year. This does not include cancelled calls.

The volunteer fire department and the ambulance service in Othello are dispatched together on all calls. The fire department carries extrication equipment, which the ambulance service does not have. If either of the services is not required on a call, they are be cancelled. Because the area is so rural, it is the best way to cover all situations. The fire department does not have certified EMTs or FRs. Fire department personnel do not serve as fill-in ambulance drivers at any time. The fire department and ambulance services are both separate entities that do not cross over.

East Adams County

The policy developed for East Adams County is a 5-minute response from tone to arriving at the hospital. Two ambulances in Ritzville are housed at the hospital. The Lind and Washtucna ambulances (1 each location) are housed at their respective fire stations. The 5-minute response policy is met approximately 96% of the time. Due to volunteer personnel the other 4% of the time represents approximately 10-minute response times from tone to arriving at the ambulance.

The volunteer fire departments do not respond to medical or trauma calls other than traffic related incidents. Fire Departments do not provide first response in any of the areas of East Adams County. The reason they respond to traffic incidents is because they carry extrication equipment and the ambulances do not. Upon occasion volunteer fire fighters will serve as ambulance drivers.

NEIGHBORING AMBULANCE SERVICES

West Adams County Response Area

- Samaritan Ambulance service operated by Samaritan Hospital in Moses Lake is an ALS ambulance service located.24 miles north of Othello in Grant County.
- Connell is 18 miles south of Othello in Franklin County.
- Lind is 28 miles east, and Washtucna is 48 miles east of Othello in Adams County.
- Royal City is 24 miles west of Othello in Grant County.

Although Adams County, specifically the Othello Ambulance service, does not have written mutual aid agreements with the services listed above, there are gentlemen's mutual aid agreements (verbal agreements) between Samaritan Ambulance in Moses Lake (most frequently called), and Royal City, also located in Grant County. Generally Ritzville Ambulance is not contacted for mutual aid because of their location to Othello. The verbal agreements work very well. All services are happy with the current arrangement.

In 1994-95 there was an effort between the North Central (Grant County), South Central (Franklin County) and East Region (Adams County) to encourage mutual aid between the agencies crossing regional borders. A number of meetings were held with the appropriate representatives in attendance, however the wording of the written document could not be agreed upon and finally just was dropped. Some of the key players involved in the original negotiations are still involved in the EMS/TC System.

Northwest Medstar operates out of Moses Lake with backup out of Spokane and provides ALS helicopter response and transfers to and from Othello.

East Adams County Response Area

The following services provide mutual aid for East Adams Rural Hospital Ambulance Services: Samaritan Hospital, Othello, Colfax, Sprague, and Lincoln County. Med Star provides transport and resuscitation support as requested to the service area.

HARDSHIP

The historical demand or hardship is the same in both East and West Adams County. "The main problem is in maintaining personnel" to staff both the Ritzville and Othello ambulances. This problem has existed for the past twenty years. Daytime availability remains the weak point in this county. Lack of staffing is the common deficiency in this part of the region.

EQUIPMENT

West Adams County

Othello Ambulance owns and operates two modular Ford ambulances; one is a 1989 and the other a 1995 model.

East Adams County

East Adams Rural Hospital District owns and operates 4 ambulances. Two ambulances are located in Ritzville, one in Lind, and one in Washtucna.

NEEDS

Currently Othello Ambulance has funding for all necessary training and equipment that the service might need. The only immediate, and anticipated future need, is that of personnel. As mentioned previously, retention of providers continues to be a problem the county.

There will always be a personnel need in these small rural communities. Lind and Washtucna especially have the highest needs. Two available crewmembers need to be available at all times. With only 6 members, each crewmember must donate staffing time. Ritzville has larger base to draw from not only from current staffing resources but also for recruitment potential. EMT classes are held each year to encourage growth for each of these crews.

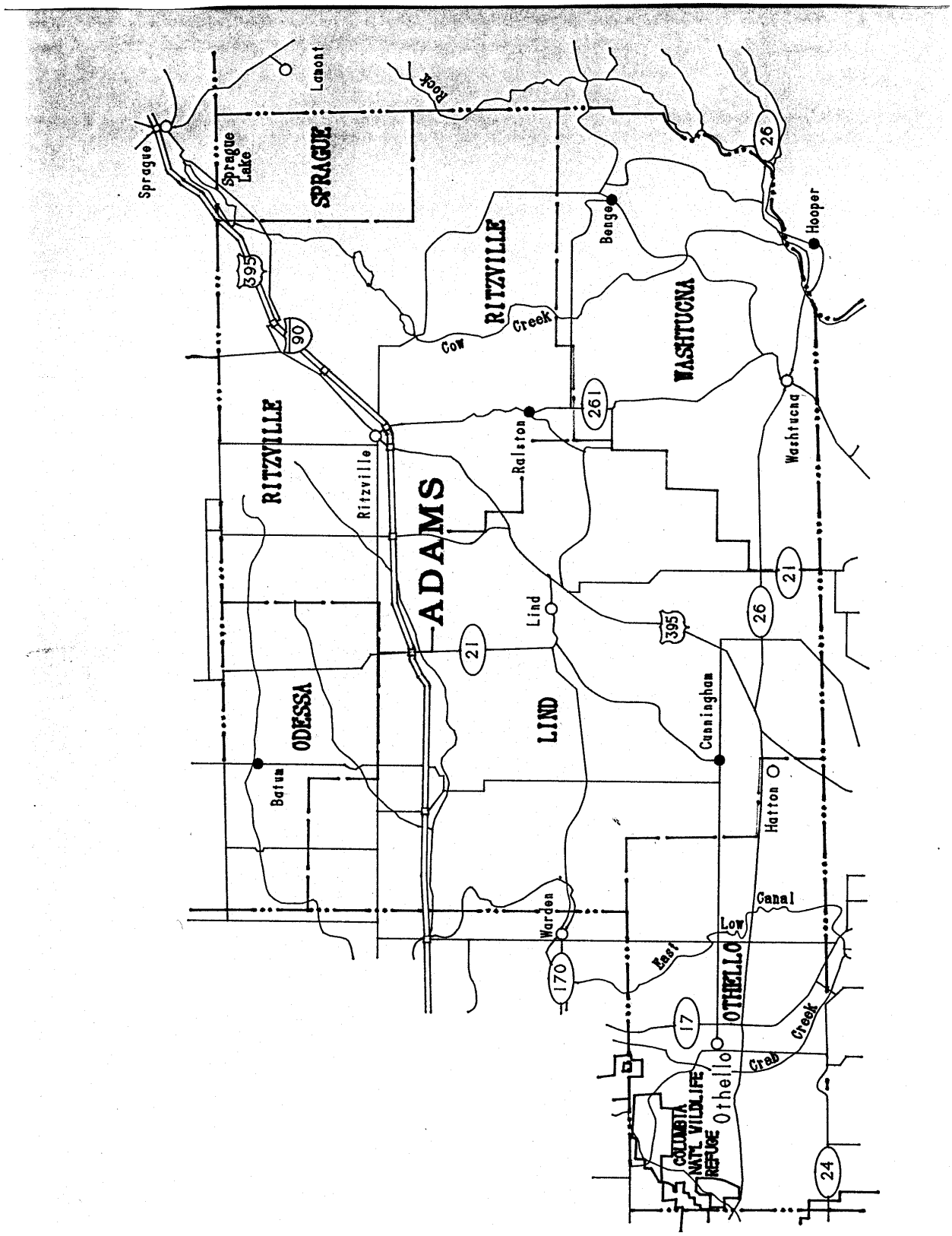
MINIMUM/MAXIMUM RECOMMENDATIONS OF VERIFIED SERVICES

The East Region EMS/TC Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Adams County is:

Adams Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	0	0	0	0	0
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	2	2	2	2	2
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

Note: The Regional office does not have an updated response area map of Adams County, however is working with Jim Parrish, East Adams Rural Hospital Administrator, to acquire one.

OLD ADAMS COUNTY RESPONSE AREA MAP



GEOGRAPHICAL AREA: Asotin County covers approximately 719 square miles in the Southeast corner of Washington State. The topography ranges from 730 feet along the Snake River to over 5,800 feet on Mt. Horrible in the Umatilla National Forest. Much of Asotin County is rural or wilderness, with unimproved road systems which impact response times and the nature of medical calls.

WEATHER, ENVIRONMENTAL FACTORS RELATIVE TO MEDICAL RESPONSES: Asotin County is considered the "Banana Belt" of Washing State. The Cascades, Blue Mountain range provides shelter to the Lewis and Clark Valley. Summer time temperatures range between 90-100°F; winter temperatures average 35°F; annual participation is 13 inches; average annual snowfall is 4-6 inches, below 1,500 feet elevation (where 90% of the population is located). The mild weather coupled with two river systems (Snake & Clearwater), and many camping facilities, brings thousands of visitors to the area between May and October.

DEMOGRAPHICS: The population estimate for Asotin County as of 1999* is 20,000. Most of the county population is located in the cities of Clarkston (6,915) and Asotin (1,090. Over 70% of Asotin County is unincorporated. According to the Asotin County Comprehensive plan, this is the fastest growing segment of the County. Since 1990, the population in the unincorporated areas of the county has grown by 2,100. Where as the City of Clarkston has only increased 500+. The median age of those living in Asotin County is 35** (45-49 according to the 1999 data book). An interesting demographic is in the City of Clarkston, where it is projected that 40% of the City's population will be over 50 in the year 2000. Currently 24% of the County population is over 55 years. The population density is 7,000 people per square mile in Clarkston; it is approximately 16.7 in the rural areas.

Source: *Asotin County Comprehensive Plan page 33
*U.S. Bureau of the Census, 1990, page 37

THE EMERGENCY MEDICAL RESPONSE AND FACILITY SYSTEM:

- Medical Program Director: Kurt Martyn, M.D. Tri-State Hospital Emergency Room
- Facilities: St. Joseph Regional Hospital Lewiston (Type II Trauma) and Tri-State Hospital Clarkston (Type IV Trauma)
- Transport Agency: Lewiston Fire Department, Lewiston ID
- Emergency Medical First Response Agencies:
    - Clarkston Fire (ILS), Clarkston, Asotin, Asotin County
    - Lewiston Fire (ALS) Transport Agency*

* Covers wilderness response areas with additional staffing from Clarkston Fire.

POLITICAL SUBDIVISION	LEGAL DESCRIPTION
City of Clarkston Fire Dept. 820 Fifth Street Clarkston WA 99403 1 Fire Chief Paid (EMT-B) 5 Firefighters/Paramedics 1 Captain/Paramedic 2 Captains/ILS 25 Volunteers 20 EMTs 5 Firefighters	Sections 20, 21, 28, 29 T-11N Range 46 East Asotin County, Washington
City of Asotin Fire Department 207 Second Street Asotin WA 99402 1 Fire Chief Volunteer 4 Firefighters Volunteer 2 Firefighter/EMT-B's Volunteer	Section 21 T-36N Range 46 East Asotin County Washington
Asotin County Fire District #1 2314 Appleside Blvd. Clarkston WA 99403 1 Fire Chief Paid 26 Firefighters Volunteer 4 Firefighter/EMT-B's Volunteer	Sections 7,8,19,21,22,23 Range 45 East T-36N Sections 1-36 Range 44E T-10N Sections, 35,36,1,2,3,4,5,6,10,11,12,12,14,15,22,23,24,25,26,27 ,34,35,36 Range 43E T-10N Sections 21,22,23,24,25,26,27,36 Range H5E T-10N Asotin County
Asotin County Sheriff Asotin Washington River Rescue* 1 EMT 6 First Responders	Snake River Clearwater River

***Staffing augmentation from Clarkston Fire**

Asotin County residents enjoy a tiered response that in the suburban area is better than many larger cities or counties. For example, in 90% of the City of Clarkston, two paramedics are on scene within 2.5 minutes, additionally 2 additional paramedics from Lewiston Fire arrive in the ambulance within 4-6 minutes (this is a tiered response).

Residents also enjoy two outstanding hospitals that work hard to help the pre-hospital delivery system. This is done by on-going EMS training and Quality Control. Most residents in the suburban area can be at a hospital within 5-7 minutes after stabilization.

SERVICE DEMANDS: Clarkston Fire (Rescue I) set a record for EMS responses in 1999 with 1,438 emergency medical responses. In 1999, 6 of these calls were trauma tag calls, 4 of the 6 calls were multi-system traumas. Lewiston Fire Ambulance responded to Asotin County 1318 times in 1999. The calls for service are expected to increase steadily as the population age increases.

Approximately 57% of EMS calls are in the City of Clarkston,
4% in City of Asotin, and 37% on the County area (the other 2% are out of area or mutual aid calls).

As previously stated much of Asotin County is classified rural or wilderness. The Rescue I Levy Zone and response area is approximately 27 square miles. Lewiston Fire makes responses outside of this zone with staffing augmented by Clarkston Fire.

VERIFIED AID AND AMBULANCE SERVICES :

Clarkston Fire Department (ILS)
820 Fifth Street
Clarkston Washington 99403
O2MO2 Expires 9-30-2001
2 Rescue Units (ILS) 1 Engine (ILS)

Lewiston Fire Department (ALS)
300 13th Street
Lewiston Idaho 83501
4OMO1 Expires 9-30-2000
7 Ambulances (ALS) 1 Rescue Unit

Air Transport*
Northwest Med-Star (ALS)
Spokane Washington
32X07 Expires 9-30-2001
Flight Time: 40 minutes

MINIMUM - MAXIMUMS RECOMMENDATIONS FOR VERIFIED SERVICES
In November of 1998, as per Regional EMS/TC Council request, the Asotin County EMS/TC Council provided the following recommendations that were adopted by the council.

The East Region EMS/TC Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Asotin County is:

Asotin Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	0	0	0	0	0
Aid - ILS	X	1	1	1	1	1
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	0	0	0	0	0
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	1	1	1	1	1

*Med-Star made 29 stops at Tri-State Hospital in 1999

UNDERSERVED AREAS : Asotin County has some interesting issues relative to much of the rural, wilderness areas of the county. As previously stated, the far majority of the county population resides in and around the City of Clarkston. In Fact 80%+ live in the 27 square miles in and around the cities of Asotin and Clarkston. The remaining 682 square miles is low density and primarily scattered ranches. I think it is a fair statement to say the majority of growth will occur in Asotin County Fire District #1, in the Clarkston Heights or Cherry Road Corridor (within current Rescue One response zone).

There have been recent attempts by Asotin County Emergency Management to get rural, wilderness folks in the Anatone area into a fire district, without much success. These folks don't want to pay for such services.

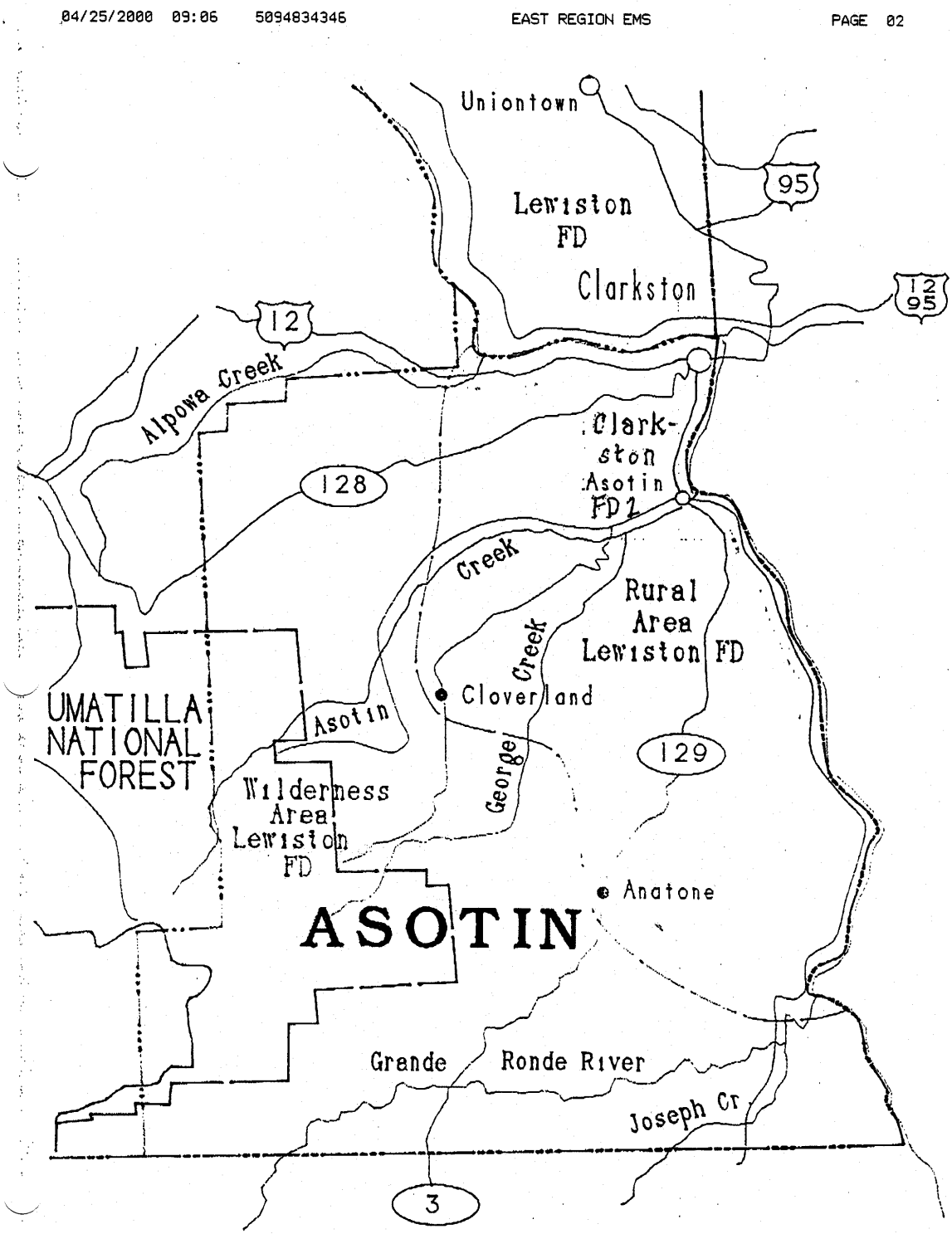
UNDER-SERVED AREA	CURRENT COVERAGE
Cloverland	Lewiston Fire 25 minutes
Anatone	Lewiston Fire 30 minutes
Snake River Road Area Hellar Bar	Lewiston Fire 45 minutes
Grande Ronde Area	Lewiston Fire 60 minutes
East Mountain Road Area (Umatilla National Forest)	Lewiston Fire 75 minutes

THE FUTURE: The Rescue One Paramedic service was started in 1983. Six of the nine full-time Clarkston personnel are funded by the annual EMS levy (see map of Levy, Response Zone). The levy has enjoyed widespread approval except in 1997, when it passed by a slim majority (63%). In 1998, 1999, the approval rate was 84% and 80% respectively.

The passage of I-695 in Washington State brings storm clouds to the horizon. The City of Clarkston projects fiscal reduction of $260,000+ in 2001, as a direct result of loss of Motor Vehicle Excise Tax (MVET) included in I-695. This potentially causes the loss of two full-time firefighters (1 paramedic, 1 EMT-b). Rescue One has enjoyed the paramedic level of service with two person minimum staffing. This reduction could threaten that level of service. In fact, the second out Rescue unit, (R-82) could well be EMT-B or First Responder level.

Granted, with Lewiston Fires' Paramedic Ambulance on scene within 4-6 minutes, in most of the levy zone, the impacts would primarily hit the outlying areas where the ambulance response is over 20 minutes (see under-served areas).

Further, the Rescue One Levy could be in real jeopardy if the Rescue One Levy amount is raised to absorb personnel costs, and dispatch costs. Since the City of Clarkston is likely to fund just one of 9 firefighters, a real threat looms. If voters continue to attack the cost of providing services and government, who knows what 2002 might bring. There is no safety net for Rescue One. If voters do not approve the levy in November, by January 1, all employees will be gone. Asotin County will be 100% BLS volunteer coverage except for paramedic ambulance coverage from Lewiston.


04/25/2000 09:06 5094834346 EAST REGION EMS PAGE 02
Uniontown
Lewiston FD
Clarkston
95
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12 95
Alpowa Creek
Clark-ston Asotin FD 1
128
Creek
Rural Area Lewiston FD
George Creek
Cloverland
UMATILLA NATIONAL FOREST
Asotin
Wilderness Area Lewiston FD
129
Anatone
ASOTIN
Grande Ronde River
Joseph Cr
3

PRE-HOSPITAL EMS AND TRAUMA SERVICES

Ferry County EMS/Trauma Care County Council has identified an area where an increase in skill level would enhance existing emergency medical services provided. The County goal is to facilitate an increase in EMS skill level to that area. The objectives and strategies are to offer EMS training and education, and assistance in needs grants process to all areas. EMS needs are identified in *Verified Aid and Ambulance Services* listed below. Each agency develops strategies and works with the County Council to assist in EMS training, obtaining needed equipment, and other needs identified in the process.

CURRENT DEMAND AND NATURE OF THE SYSTEM

The Ferry County EMS/Trauma Care County Council recognizes that the vast rural and wilderness areas contribute to long EMS response and transport times. With this in mind, the Council supports the implementation of Intermediate Life Support (ILS) trained EMTs in Ferry County.

Many of our patients are transported to Spokane, Colville, Tonasket, Omak, or Brewster due to the lack of advanced medical equipment available in Ferry County.

Geography Of The Area To Be Served

Ferry County is located in northeastern Washington State. The northern half of the county is composed of the Colville National Forest while the southern half if part of the Colville Indian Reservation. The terrain is mountainous and heavily forested. It is flanked on the west by Okanogan County, the south by Lincoln County, the east by Lake Roosevelt (formed by the back waters of the Grand Coulee Dam/Columbia River) and Stevens County, and on the north by British Columbia, Canada. State Route 21 travels north and south near the county's western border and State Route 20 and 21 junction at the City of Republic, the county seat for Ferry County. Access into Canada is through Ports of Entry at Danville on Highway 21, 32 miles north of Republic; at Midway on Highway 21, 45 miles north of Republic; and at Laurier on Highway 395, 68 miles northeast of Republic.

The tribal lands are outside the jurisdiction of the ambulance services discussed in the following. As Stevens County provides ambulance transport service to the Laurier – Barney's Junction corridor, that area is also not discussed in the minimum/maximum recommendations by the Ferry County EMS/Trauma Care County Council.

The towns of Danville, Curlew, Malo and surrounding areas are served by the Ferry/Okanogan Fire Protection District #14, Ambulance Division (North Ferry County Ambulance). Republic and surrounding areas are served by Ferry County/City of Republic EMS District #1(Ferry County Ambulance). The Laurier - Barney's Junction corridor is served by BLS aid units from Stevens County #8/Ferry County #3 Fire District, with ambulance transportation provided by Steven's County Sheriff's Ambulance. All of these aid and ambulance services rendezvous with Med Star Air/Ground Ambulance when patient injury/condition warrants.

1. POPULATION SERVED, INCLUDING DEMOGRAPHY
(Source: State of Washington 1999 Data Book)

a) **Population by age and gender**:

Age	Females	Males	Total
0 – 4	231	241	473
5 - 9	285	313	599
10 – 14	321	314	634
15 – 19	295	364	659
20 – 24	207	256	463
25 – 29	199	190	389
30 – 34	215	187	402
35 – 39	277	281	558
40 – 44	289	348	637
45 – 49	262	318	580
50 – 54	251	227	478
55 – 59	183	204	388
60 – 64	119	153	272
65 – 69	110	118	228
70 – 74	101	106	207
75 – 79	83	75	158
80 – 84	58	45	103
85 +	43	30	73
	3532	**3768**	**7300**

b) Mortality, by place of occurrence:

1)	Overall mortality	421
2)	Deaths by injuries	5
3)	Deaths by motor vehicle	5
4)	Deaths by drowning	0
5)	Deaths by falls	0
6)	All other trauma	0

2. Prehospital Planning Areas, rural and wilderness (from the Ferry County Planning Department):

a)	Total land area:	2,204 sq. miles
b)	Incorporated land area:	1. sq. mile
c)	Unincorporated land area	2,203 sq. miles
d)	Total population	7,300
	Population in Incorporated area:	1,040
	Population in Unincorporated area:	6,260
e)	Total Population Density per square mile	3.3
	Population density in Incorporated area:	1,040
	Population density in Unincorporated area:	2.8
f)	Proportion of population in incorporated area:	14%
g)	Proportion of population in unincorporated areas:	86%

VERIFIED AID AND AMBULANCE SERVICES

The Ferry County EMS/Trauma Care County Council carefully evaluated existing EMS services, geographic location served, EMS response time, numbers of trauma calls, and possible future needs to determine minimu m and maximum numbers and levels of EMS services when making recommendations to the Regional Council. Ferry County's EMS agencies are striving to increase EMS skills and trauma verification levels. In the recommendation process, the County Council identified the specific geographic service areas using established and recognized fire district and EMS district boundaries. Political climate, lack of human and financial resources, and low EMS call volume is the barriers to establishing EMS services in any areas that do not lie within Fire/EMS District boundaries. Much of this land is National Forest, used seasonally for recreation and has no permanent population.

The towns of Danville, Curlew, Malo, and surrounding wilderness areas are served by Ferry/Okanogan Fire Protection District #14, Ambulance Division (North Ferry County Ambulance). In 1996, 2200 acres of Okanogan County were annexed into the Fire District. The ambulance service is a volunteer agency with two ambulances and an extrication unit.* ALS rendezvous is provided by Med Star air or ground ambulance. Because of the proximity of the Canadian Border, critical patients are occasionally transported to Boundary Hospital in Grand Forks, British Columbia.

> **Note: The original statement "Due to lack of funds, the extrication unit is currently not equipped with extrication equipment but is used for off-road rescue" was deleted from the text because the statement could not be verified. Extrication equipment was not included as a need for this same reason.*

***NEED**:* Due to the large area served and the long transport times, the County Council recommends an increase in EMS skills to ILS for North Ferry County Ambulance. This ambulance service currently has one ILS trained EMT. Because there is only one EMT-I, the County Council is not recommending the ambulance service upgrade its trauma verification level to ILS at this time.

The city of Republic and surrounding wilderness areas are served by Ferry County/City of Republic EMS District #1 (Ferry County Ambulance). The ambulance service is a volunteer agency with three ambulances and an extrication unit. ALS rendezvous is provided by Med Star air or ground ambulance.

***NEED**:* The demands of the area are adequately met by the ambulance agencies currently providing service. This is reflected in the minimum/maximum recommendations of the County Council.

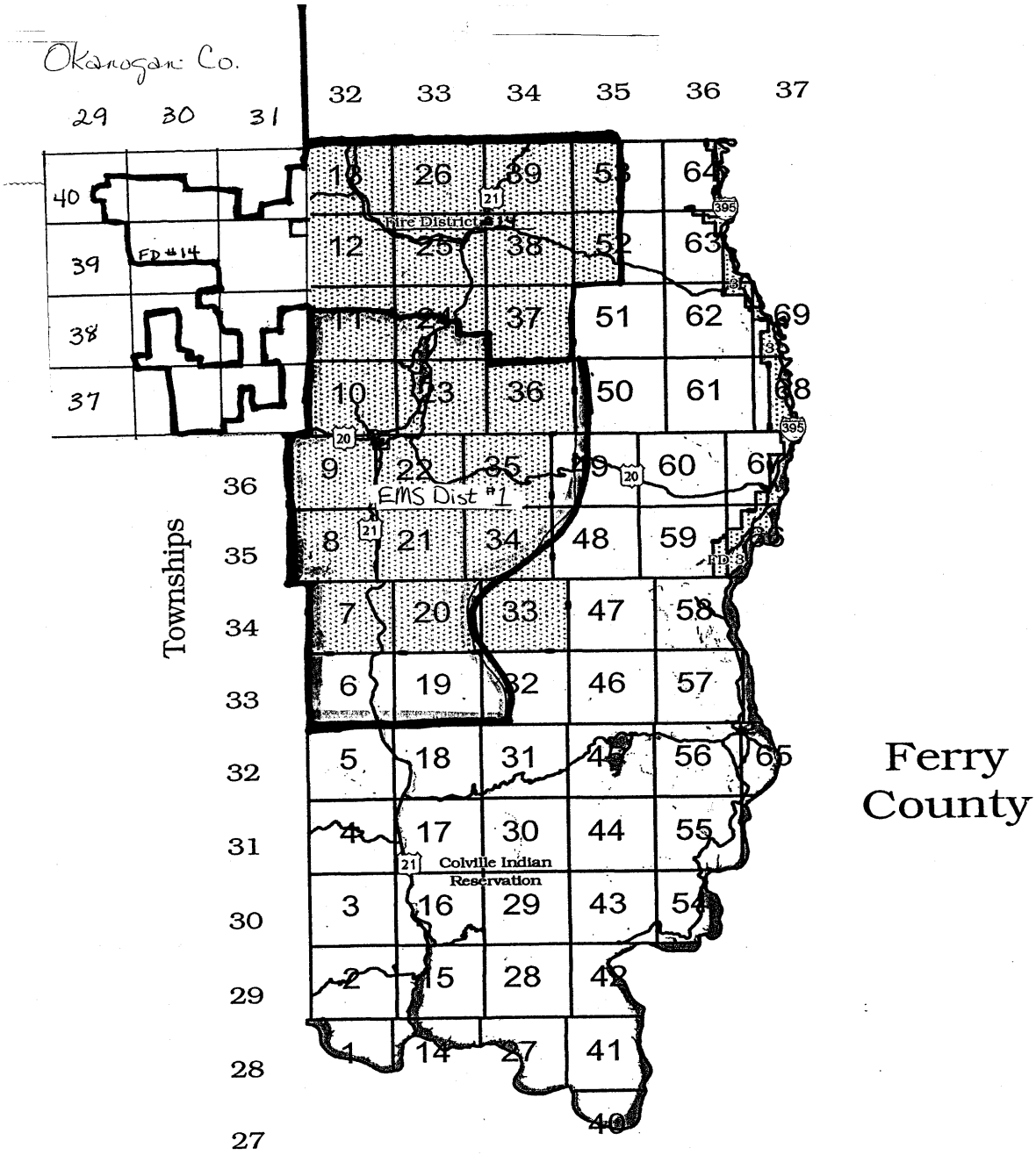
Taking into consideration the geography and demographics of Ferry County, the Ferry County EMS/Trauma Care County Council makes the following minimum/maximum recommendations to the Regional Council:

MINIMUM/MAXIMUM RECOMMENDATIONS OF VERIFIED SERVICES

Taking into consideration the geography and demographics of Ferry County, the Ferry County EMS/Trauma Care County Council made the following minimum/maximum recommendations to the Regional Council.

The East Region EMS/TC Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Ferry County is:

Ferry Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	0	0	0	0	0
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	2	2	2	2	2
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0


Okanogan Co.
29
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Townships
FD #14
Fire District #13
EMS Dist #1
Colville Indian Reservation
Ferry County

AREA PROFILE

Garfield County is located in the Palouse Hills and Blue Mountains regions of Southeastern Washington. It comprises a total landmass of 706 square miles (1.1 percent of the state's total land mass). Garfield County ranks 33rd in size among Washington counties.

The county is bounded to the north by Whitman County (which is separated by the Snake River), to the west by Columbia County and to the east Asotin County. Its southern boundary is the Washington-Oregon border.

The county's southern panhandle is rugged and densely forested as it represents the northernmost extension of the Blue Mountains (most of the range lies in Oregon.) This range also falls under the jurisdiction of the US Forest Service as it is designated as part of the Umatilla National Forest and the Wenaha-Tucannon Wilderness Area.

The northern part of Garfield County extends from the foothills of the Blue Mountains to the Snake River. At the northernmost boundaries, the river has cut an enormous canyon into earth. The Snake River Canyon descends as much as 2,000 feet in places along the county border.

The economy is based almost entirely on farming, cattle production and grass seed. Much of the county is isolated and has many acres accessible only by four-wheel terrain vehicles. The county is classified as frontier rural because of its geographic isolation and the nature of its life style. It is tied to other areas by a single east west highway. The single town in the county is Pomeroy. The population density of people per square mile is 3.3.

The Counties goal is to maintain it's current EMS services. There are written agreements with all of the surrounding counties for mutual aid, we have one (1) verified and licensed agency in the county. (12D01) Fire District #1, we have two (2) ambulances (one of which is for transport) There are 14 (fourteen) EMTs with BLS, PTL and Defibrillator training. There are five (5) first responders.

POPULATION

The population in Garfield County is getting older. The 1999 census was 2,400 of these 472 were 65 years and older. The county's median age is 41.1. The county has fewer younger workers relative to the state and a considerably larger population of older workers and retirees.

UNEMPLOYMENT - Rate is 3.6%

PRE-HOSPITAL PLANNING AREAS

Land Area 706 square miles
Total population
County 2400
Pomeroy 1460
Population unincorporated 995
Population incorporated 1445
Population Density per square mile 3.4
City of Pomeroy covers an area of approximately three miles in length and 1.5 miles in width.
Wilderness area 177,465 acres

Mortality	1998	1999	2000(Jan-Aug)
Electrical	1	0	0
MVA	4	0	0
Intentional injury	0	3	0

In 1999, Garfield County had three local citizens with fatal intentional injuries, one however, occurred outside of the county in Whitman County. Since he was a resident I did include him.

The Number Of Ambulance Runs:
1998--112
1999—96
2000—86 (January thru August)

The response area of responsibility for 12D01, Fire District #1 in Pomeroy, WA is all of the geographic area of Garfield County, with mutual aide agreements signed with the three surrounding counties for support. A map is on file in the East Region Council office of the EMS response area within our county.

LICENSED AND VERIFIED AMBULANCE SERVICE
The Garfield County Fire District #1 offers BLS service and has excellent response times in the town, (rural) usually less than five (5) minutes. The county rural/wilderness areas response with time is ASAP. The EMTs and First Responders are all volunteers with the exception of one paid coordinator for the county. There is a location in the Blue Mountains on the Asotin County side that is sometimes responded to by the Asotin County EMT group. On scene time is also within the state parameters. We have a limited number of trauma calls. We do not anticipate the need to change our minimum (1) or maximum (1) numbers in the foreseeable future. The Ambulance Memorial Fund traditionally has been generous to the agency in helping to upgrade equipment, supplies and high budget items. The East Region has an excellent Training Program with a traveling van, the MPD and the local Nurse Practioner and another EMT, RN help with the continuing education requirements. When there is a need for ALS, usually the EMTs establish contact with the ALS Lewiston Fire Department for rendezvous as indicated in our County Operating Procedures and by mutual aid agreements.

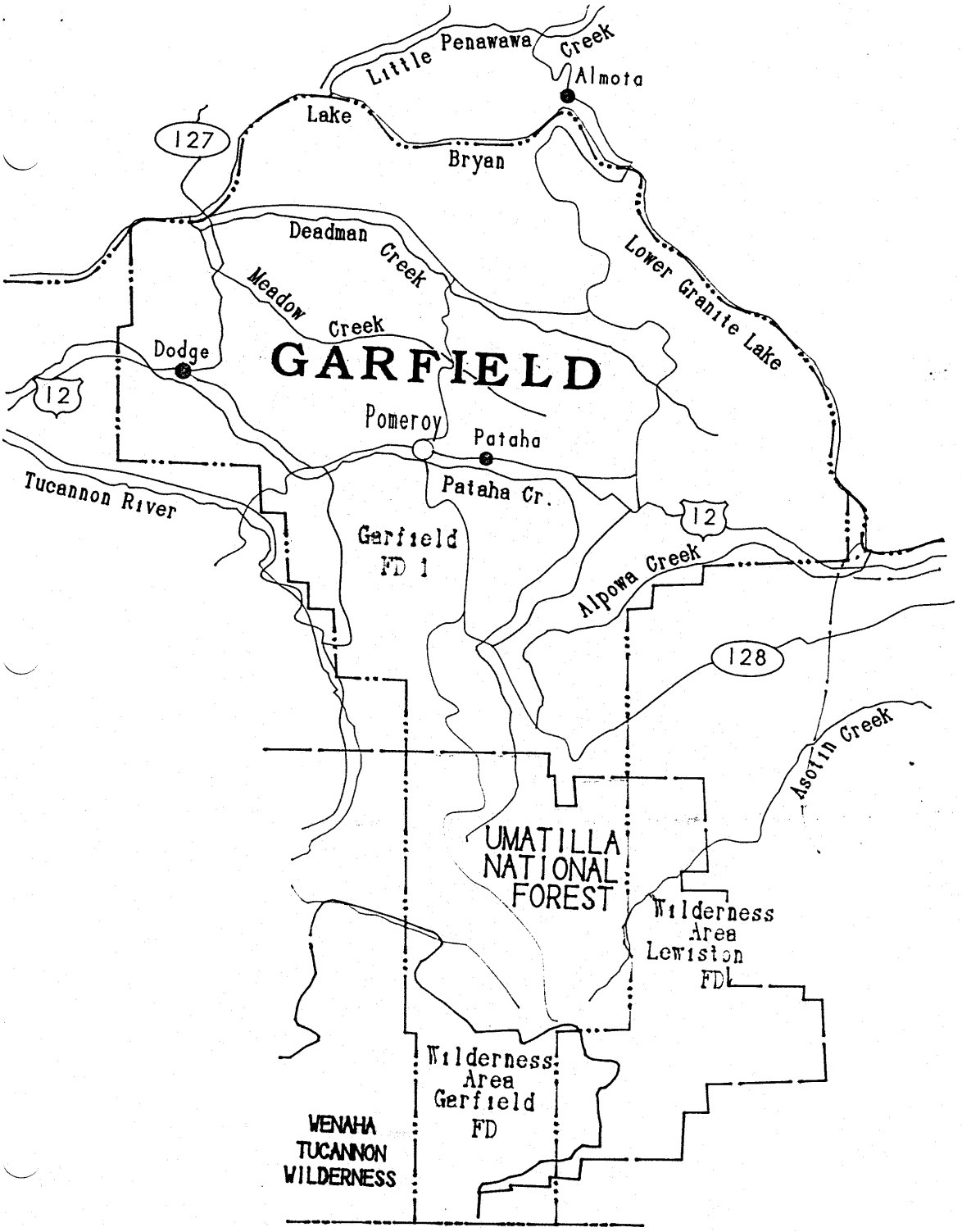
The level of verification for our Counties verified and licensed service is BLS, there is no need identified at this time for a change. We are unable to consider ILS or Paramedic training at this time, because of the volunteer status and full time jobs to fulfill and the lack of ongoing experience after their certification for IV's and etc. We presently have no underserved areas.

EAST REGION MINIMUM/MAXIMUM RECOMMENDATIONS (VERIFIED SERVICES)

The East Region EMS/TC Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Garfield County is:

Garfield	Check if	Current	Minimum Number		Maximum Number	
Services	No Change	Status	Approved	Recommended	Approved	Recommended
Aid - BLS	X	0	0	0	0	0
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	1	1	1	1	1
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

- There is no change in this recommendation from those numbers already approved.


Little Penawawa Creek
Almota
Lake
127
Bryan
Deadman Creek
Meadow Creek
Lower Granite Lake
Dodge
GARFIELD
12
Pomeroy
Pataha
Pataha Cr.
Tucannon River
Garfield FD 1
12
Alpowa Creek
128
Asotin Creek
UMATILLA NATIONAL FOREST
Wilderness Area Lewiston FD
Wilderness Area Garfield FD
WENAHA TUCANNON WILDERNESS

AREA PROFILE

Lincoln County is located in the central eastern part of Washington State. It has a population of approximately 10,000 people in a area of approximately 2,500 square miles. Of the population 4,251 is unincorporated and 5,749 is incorporated.

The northern part of the county is bordered by the Spokane River on the east portion and the Columbia River (Lake Roosevelt, the back waters of Grand Coulee Dam) on the west portion. It is flanked on the south by Adams County, the east by Spokane County and the west by Grant County. The topography is diverse and can range from forested land to wheat fields, to channeled scablands. We are rural with very little urban development. State Route 2 travels east-west through the county and is the main two-lane highway to Seattle via Stevens Pass. Interstate 90 passes through the southwestern corner of the county.

Lake Roosevelt is a nationally recognized recreation area. It has approximately 800,000 visitors a year to the various campgrounds and boat launching facilities. (This information is from the National Park Service.)

Lincoln County has one area that is not in any fire or EMS area at this time. It is in the northwestern part of the county. This area is along the Columbia River on Lake Roosevelt, on our map it is in the area that is circled. This is the Spring Canyon and Neal Canyon area. At this time, units from Grand Coulee, Wilbur and National Park Service do respond to this area. It is two miles from the Grant County line.

MINIMUM/MAXIMUM RECOMMENDATIONS FOR VERIFIED SERVICES

The East Region EMS/TC Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Garfield County is:

Lincoln Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	2	2	2	2	2
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	6	6	6	6	6
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

ALMIRA

Almira is served by Lincoln County Fire District #8 for fire and EMS. It is a two-tiered response. The Almira fire department provides BLS first response with EMS transport provided by Wilbur Ambulance, a BLS service. Northwest Medstar provides ALS air ambulance service.

Almira First Response serves approximately 176 square miles, with the town of Almira having a population of approximately 304 people.

CRESTON

Creston is served by Lincoln County Fire District #7 for fire and EMS. Creston has one Ambulance, a BLS service. Northwest Medstar provides ALS air ambulance service.

Creston Ambulance, verified by the DOH in November of 2001, serves approximately 195 square miles, with Creston having a population of approximately 250 people.

DAVENPORT

Davenport is served by Davenport Ambulance, a BLS service. It has two ambulances. It is based out of Lincoln Hospital District #3, which is a level IV trauma facility. Northwest Medstar provides ALS air ambulance service.

Davenport Ambulance serves approximately 579 square miles. It provides not only service to the Davenport area, but also transports for the Reardan-Edwall area.

The city of Davenport has a population of approximately 1,778 people.

REARDAN-EDWALL

Reardan-Edwall is served by Lincoln County Fire District # 4 for fire and EMS. It is a two-tiered response. The Reardan-Edwall fire department provides BLS first response, with Davenport Ambulance, Sprague Ambulance, Wellpinit Ambulance, and American Medical Response providing BLS transport services. American Medical Response and Northwest Medstar provide ALS transport.

Reardan-Edwall first response serves approximately 233 square miles. The town of Reardan has a population of approximately 610 people and the town of Edwall has a population of approximately 100 people.

HARRINGTON

Harrington is served by Lincoln County Fire District # 6 for fire and EMS. It has one ambulance, a BLS service. Northwest Medstar provides ALS air ambulance service.

Harrington serves approximately 278 square miles, with the town of Harrington having a population of approximately 482 people.

ODESSA

Odessa is served by Odessa Ambulance, a BLS service. It has two ambulances. It is based out of Lincoln Hospital District # 1, which is a level 5 trauma facility. Northwest Medstar provides air ambulance service.

Odessa Ambulance serves approximately 503 square miles. The city of Odessa has a population of approximately *975* people.

SPRAGUE

Sprague is served by Lincoln County Fire District #3 for fire and EMS. It has one ambulance, a BLS service. It is BLS transport service for part of the Edwall area. American Medical Response and Northwest Medstar provide ALS transport.

Sprague serves approximately 224 square miles, with the town of Sprague having a population of approximately 455 people. Sprague has approximately 16 miles of Interstate 90 in their district.

WILBUR

Wilbur is served by Lincoln County Fire District #7 for fire and EMS. It has one ambulance, a BLS service. It is BLS transport service for Almira. Northwest Medstar provides ALS air ambulance service.

Wilbur Ambulance serves approximately 452 square miles, with the city of Wilbur having a population of approximately *895* people.

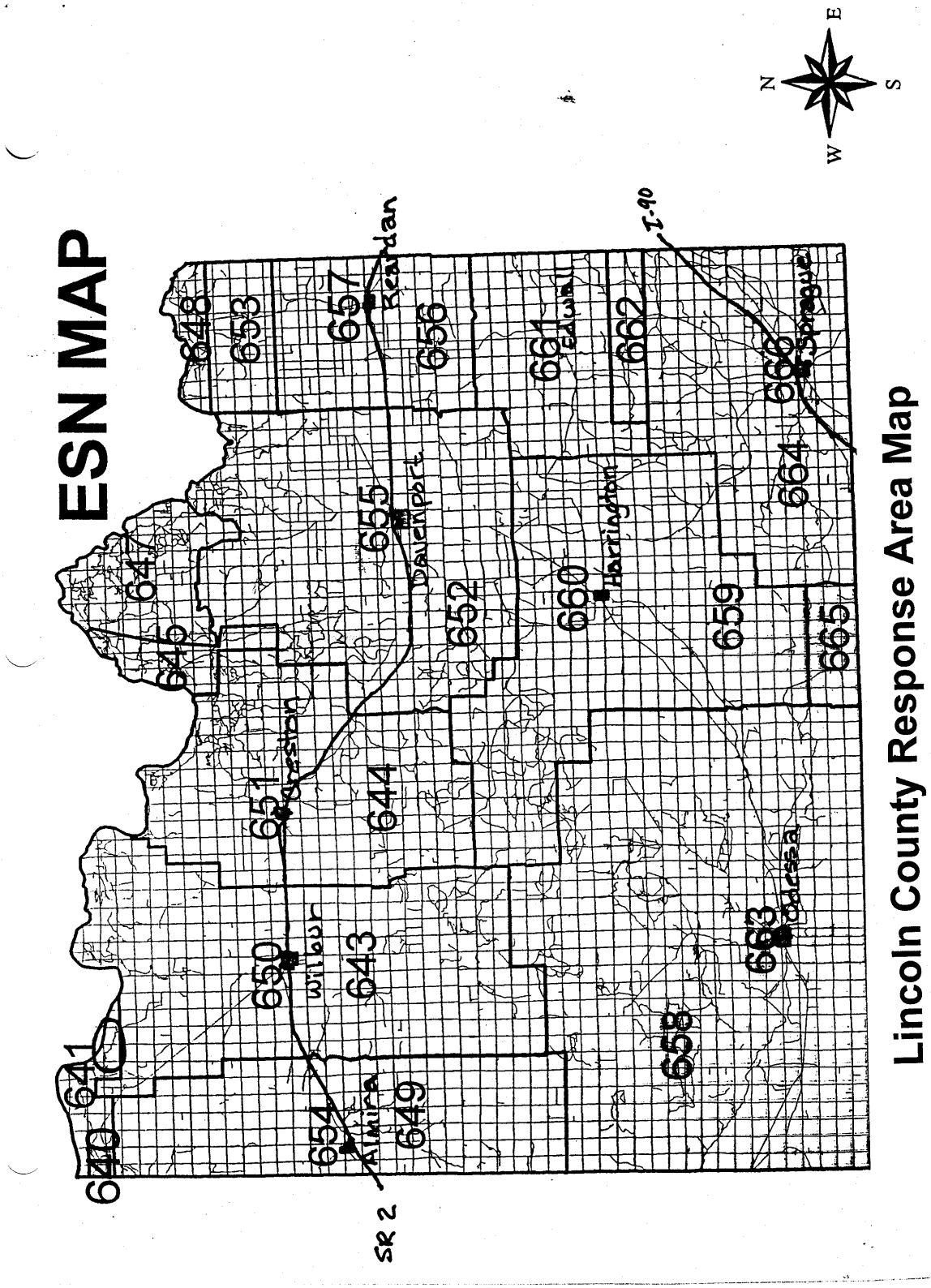
NATIONAL PARK SERVICE

The National Park Service is an affiliate service. It services Lake Roosevelt and campgrounds along the Columbia River.

SERVICE GOALS

The county's goal is to maintain it's current EMS services. The EMTs and First Responders are all volunteer. We provide service 24 hours a day, 7days a week. On scene time is within the state parameters. There are mutual aid agreements between all of the agencies in Lincoln County. Lincoln County has mutual aid agreements with all of its surrounding counties. This provides adequate service with no duplication. We help each other out by training together or lending personnel if needed.

The recommended level of training for our county's verified and licensed service is BLS. The only foreseeable need is to assist the establishment of a first response unit with the Seven Bays / Deer Meadows fire services with transport services provided by the Davenport Ambulance. We presently have no underserved areas.


ESN MAP
Lincoln County Response Area Map
N
E
S
W
I-90
Reardan
Davenport
Harrington
Wilbur
Creston
Almira
Odessa
Sprague
SR 2
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Emergency Service Zone Number	**Fire District Number**	Ambulance & Aid Services **R=Aid Responder T=Transporter**	**Law Enforcement**	**Comments**
640	Grand Coulee	R-Grand Coulee	LCS	
	9	T-Grand Coulee		
643		R-Wilbur		
	7	T-Wilbur		
644		R-Creston	LCS	
	7	T-Creston		
645	Seven Bays Fire	R-Davenport	LCS	Seven Bays Development
	5	T-Davenport		
647	Egypt Fire	R-Davenport	LCS	
648	Long Lake Fire District	R-Reardan R- Long Lake	LCS	▪ Reardan PM Responder ▪ Long Lake AM Responder
		T-Wellpinit		
649		R-Almira	LCS	
	8	T-Wilbur		
650		R-Wilbur	Wilbur City Police	Town of Wilbur
	7	T-Wilbur		
651		R-Creston	LCS	Town of Creston
	7	T-Creston	LCS to Creston	
652		R-Davenport	LCS	
	5	T-Davenport		
653	Long Lake Fire District	R-Reardan R-Long Lake T-Davenport	LCS	▪ Reardan PM Responder ▪ Long Lake AM Responder
664		R-Almira	LCS for Almira	Town of Almira
	8	T-Wilbur		
655		R-Davenport	City Policy	Town of Davenport
	5	T-Davenport		
656		R-Reardan	LCS	
	4	T-Davenport		
657		R-Reardan	City Police	Town of Reardan
	4	T-Davenport		
658		R-Odessa	LCS	
	3	T-Odessa	LCS	
659		R-Harrington	LCS	
Law	6	T-Harrington		
660		R-Harrington	City Police	Town of Harrington
	6	T-Harrington		
661	Edwall Fire	R-Edwall	LCS	
	4	T-Davenport		
602	Edwall Fire	E-Edwall	LCS	
	4	T-Sprague		
663		R-Odessa	City Police	Town of Odessa
	3	T-Odessa		

Emergency Service Zone Number	**Fire District Number**	Ambulance & Aid Services **R=Aid Responder T=Transporter**	**Law Enforcement**	**Comments**
664		R-Sprague	LCS	
	1	T-Sprague		
665	Adams County FD #1	R-Ritzville T-Ritzville	LCS	
666		R-Sprague	LCS to Sprague	Town of Sprague
	1	T-Sprague		
667	USDA Bureau of Land Management	R-Davenport T-Davenport R-Davenport	LCS & BLM Ranger LCS	Federal Agency
668	USDA National Park Service	R-Davenport T-Davenport	LCS & NPS Ranger	Federal Agency
669	Washington Dept. of Fish & Wildlife	R-Davenport T-Davenport	LCS & Game Warden	State Agency
670	Washington Dept. of Natural Resources	R-Davenport T-Davenport	LCS & DNR Agents	State Agency

NATURE AND DEMANDS OF THE SYSTEM

Pend Oreille County is comprised of a vast wilderness area, many small-unincorporated communities, plus 5 incorporated municipalities. Response and transport times are often prolonged, and both transport agencies in the county have attempted to minimize this impact by offering ILS and ALS services as often as possible.

The majority of the patients are transported to Newport Hospital. Other transport destinations include Mt. Carmel Hospital in Colville (Primarily from ambulance zone 2), and Spokane area hospitals.

GEOGRAPHY SERVED

Pend Oreille County is the most northeastern county in Washington State. The county has mountain ranges on the east and west sides. The Pend Oreille River and it's associated valley lies in the middle. The surrounding mountain ranges are scattered with many lakes and streams of various sizes that are heavily used for recreational purposes during the summer months.

Canada flanks Pend Oreille County to the north, with the Nelway border crossing being the only port of entry in the county. It is also flanked to the south by Spokane County, to the west by Stevens County, and to the east by Idaho.

State Route 2 in the southern part of the county connects Spokane with Newport. State Route 20 runs north and south connecting Newport and Tiger, continuing on to Colville. State Route 211 connects State Route 2 and State Route 20 at Usk, bypassing Newport. State Route 31 connects Tiger with the Canadian Border.

The Southern end of the county, is served by Newport ambulance which provides transport services for Fire District 4, Fire District 3, Fire District 6, Fire District 7, Fire District 8, as well as the City of Newport, the town of Cusick, and the south half of Fire District 5. All mentioned fire districts and the town of Cusick provide BLS aid units in their respective jurisdictions.

The northern end of the county is served by Fire District 2, which provides transport services for the towns of lone, Metaline, Metaline falls, and the northern half of fire district 5. The town of lone operates a BLS aid car that is contracted by the fire district for first response in the southern end of the district. The fire district operates 2 BLS engine comp anies and 1 paramedic aid car in addition to the two BLS ambulances.

Population Served - 11, 100
Unincorporated: 8,020

Incorporated Populations - 3080

Cusick:	246
Ione:	452
Metaline:	172
Metaline Falls:	230
Newport:	1980

Median age is 38

Average population density is 7.9 persons per square mile

VERIFIED AID AND AMBULANCE SERVICES

Transport services in the south end of the county, as well as first response in the City of. Newport, is covered by Newport Ambulance, currently licensed as a BLS transport agency. Newport Ambulance is attempting to upgrade to an ILS agency, and currently employs 4 paramedics, allowing for ALS staffing a majority of the time. An additional transport service available upon request is the Ambulance at the Ponderay Newsprint at Usk. Deer Park Ambulance also responds to requests from Newport Ambulance and Fire District 2 Ambulance.

Fire Districts 8, 7, 6, 5, 4, and 3, as well as the town of Cusick operate BLS aid units, with extrication provided by Fire District 4 and Spokane County Fire District 4 through mutual aid agreements.

Fire District 2, currently licensed as a BLS transport agency, covers transport services in the northern end of the county as well as first response in the towns of Metaline, and Metaline Falls. Fire District 2 employs 1 paramedic and has 3 ILS techs on staff that allows ILS services a majority of the time. Two BLS engines provide first response in the north end of the district. All EMS units in Fire District 2 are equipped with defibrillators.

Fire District 5 and the town of Ione operate BLS aid units with extrication provided by the Ione Fire Department and Fire District 4 through a mutual aid agreement.

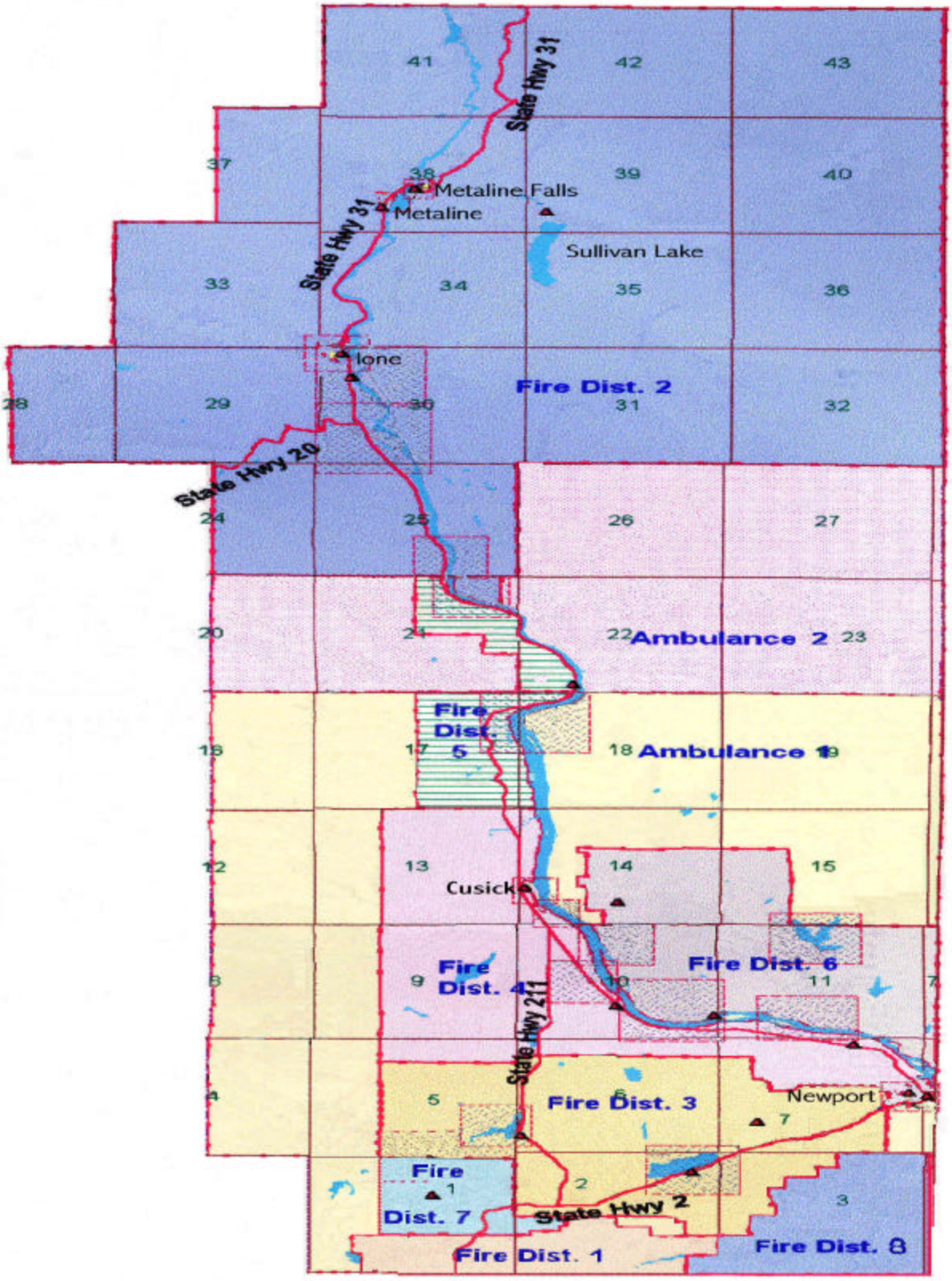
NEEDS

No needs have been identified at this time for Pend Oreille County; however, Fire District #2 is in the process of building a fire station on North LeClerc Road with an aid car for first response.

MINIMUM/MAXIMUM RECOMMENDATIONS FOR VERIFIED SERVICES

The East Region EMS & Trauma Care Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Pend Oreille County is:

Pend Oreille	**Check if**	**Current**	**Minimum Number**		**Maximum Number**	
Services	**No Change**	**Status**	**Approved**	**Recommended**	**Approved**	**Recommended**
Aid - BLS	X	7	6	6	7	7
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	3	2	2	3	3
Amb - ILS	X	0	0	0	1	1
Amb - ALS	X	0	0	0	0	0


41
42
43
State Hwy 31
37
38
39
40
Metaline Falls
Metaline
State Hwy 31
Sullivan Lake
33
34
35
36
Ione
Fire Dist. 2
28
29
30
31
32
State Hwy 20
24
25
26
27
20
21
22
Ambulance 2
23
Fire
Dist.
5
16
17
18
Ambulance 1
19
12
13
Cusick
14
15
8
9
Fire
Dist. 4
Fire Dist. 6
10
11
7
State Hwy 211
4
5
6
Fire Dist. 3
Newport
7
Fire
1
2
3
Dist. 7
State Hwy 2
Fire Dist. 1
Fire Dist. 8

AREA PROFILE

Spokane County is located at the eastern edge of Washington State bordered by Stevens and Pend Oreille Counties to the north, Idaho to the east, Whitman County to the south and Lincoln County to the west. An estimated population of 414,500 (est. Office of Financial Management 1999) lives and works in a county, which stretches from a state park mountain ski area to the second largest city in the state. It includes rolling farmlands on the Palouse, large forested areas and even a patch of dessert. The Spokane River runs through the county and numerous lakes provide recreation areas. Interstate 90 and other US and State Highways, the Spokane International Airport as well as major rail lines provide transportation to and through the county. Three Universities make Spokane County their home and several others have branch campuses here. The county is the major medical and trade center for eastern Washington, north Idaho and western Montana.

The Spokane County Council has determined that the jurisdictional boundaries of the Cities and Fire Districts shall be considered as separate response areas for the purpose of distribution of services planning. Agency descriptions, their role and place in the county system are broken down and discussed with this in mind.

Emergency Medical and Trauma Services in Spokane County are provided by a tiered response system including city fire departments, county fire districts, and private companies. For the most part Basic Life Support is provided by the Fire Department with Advanced Life Support being provided by American Medical Response and Deer Park Ambulance. The notable exceptions are Spokane City Fire Department, Spokane County Fire Districts 1 and 9. These agencies maintain 24 hour a day Advanced Life Support Aid Units in addition to their Basic Life Support coverage. With the exceptions noted on the enclosed map (attachment A) Spokane County is fully covered by Basic Life Support Aid Response. The 2 exceptions to tiered response are the rural/wilderness areas to the north (wilderness 1 on attachment A) and south (wilderness 2 on attachment A) of the eastern edge of the county. These areas are covered by private ambulance response only. They are primarily undeveloped without the resources to support a Basic Life Support aid service. The Riverside State Park area, while not inside the boundaries of any entity, is under contract with Spokane County Fire District 9 for response services.

The Intermediate Life Support level of care is a newly established certification for individual providers. Its impact and value in the suburban arena of trauma care has not been fully evaluated in Spokane County. Further there is not sufficient information available to adequately assess its potential impact versus benefit in a largely ALS area. Gathering this information and applying it to future editions of this plan is an identified need.

The entire county is serviced by the Combined Communications Center providing 24 hour a day dispatch by Emergency Medical Dispatch certified personnel. E911 is available county wide for system access. Dispatch is accomplished through digital paging and sophisticated computer interlinks with American Medical Response Dispatch Center. All public and private entities are dispatched by one of these two means. The two-way radio traffic is managed by the Combined Communication Center on several repeated frequencies with non-repeated frequencies available for scene operations.

The Inland Fire Chiefs Association has been the leader in creating and promoting countywide mutual-aid agreements including Major Incident Support Teams, Area Coordination for all risk events, and a Spokane County wide Ambulance Ordinance. These agreements have proven invaluable on several occasions within Spokane County. In addition there are several other localized mutual and automatic aid agreements between agencies with specific needs.

MINIMUM/MAXIMUM RECOMMENDATIONS OF VERIFIED SERVICES

The response time data in attachment C was used in assessing the adequacy of the Spokane County minimum/maximum numbers. As evidenced in Appendix C the current distribution and number of agencies is proving to be adequate to the needs of the county. No additional services and/or agencies are needed except in the identified wilderness areas. While no additions or changes are being identified, it would be presumptuous to assume that none will happen. To that end, a process for working through proposed changes and the associated impacts was

established by the county council with coordination through the Inland Chiefs Association. That process is included in the next section of the plan.

The East Region EMS & Trauma Care Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Spokane County is:

Spokane Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	13	13	13	13	13
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	3	3	3	3	3
Amb - BLS	X	1	1	1	1	1
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	2	2	2	2	2

BLS AID SERVICES

Airway Heights FD
Airport Fire
Cheney FD
Millwood FD
Medical Lake FD
Fire Dist 3
Fire Dist 4
Fire Dist 5
Fire Dist 8
Fire Dist 9
Fire Dist 10
Fire Dist 11
Fire Dist 12
Fire Dist 13

BLS TRANSPORT SERVICE

Spokane County Fire District 2

ALS AID SERVICES

Spokane City Fire
Spokane Fire Dist 1

ALS TRANSPORT SERVICES

American Medical Response
Deer Park Ambulance

AIR TRANSPORT SERVICE

Northwest Med Star

(While min/max numbers for air transport is a State DOH issue the reference is included to ensure they are considered in our planning and operations.)

NON-EMERGENT TRANSPORT

Non-emergent transport in Spokane County is provided by the three verified ground transport agencies and the one Air transport agency in Spokane County. These four agencies meet the needs for non-emergent transport.

* Fire District 9 is in the application process to become a verified ALS service as noted in their needs on page 7. The BLS and ALS aid service min/max numbers are set specifically for the purpose of making this change.

PROPOSED SYSTEM CHANGES

Each EMS agency and/or their contracted designee are an integral part of the Spokane County EMS System. Any EMS agency may request a change to their existing type and level of service or to the existing minimum/maximum numbers.

Any agency may modify its designation, aid and/or transport, by using the following process:

1. Request in writing that the council consider the change.
2. Provide supporting rationales.
3. Identify the effects of the change in their existing level of service.
4. Identify the effects on the level of service provided outside their jurisdiction but within Spokane County.
5. Give notice to the affected jurisdictions.
6. Propose a mitigation plan to address any reduction in service provided to other jurisdictions that will result from this change.
7. The EMS council will provide an opportunity for the affected agencies as well as the proponent to be heard.
8. The EMS council will consider the facts and testimony and base its recommendation on the proposed change on its responsibility to the citizens of the county as per RCW 70.168.100 (1) (h).
9. The EMS Council will forward in writing their findings to the East Region Council, the proponent and the affected agencies.

Any government agency bound by law or given the authority by law to provide Emergency Medical Services may provide any level service deemed necessary by its governing electorate or board. Services may be provided by the agency and/or by contract with another party.

Upon meeting these conditions to the satisfaction of the Spokane County EMS and Trauma Council the agency request will be forwarded to the region and state as a recommended change in the regional and state trauma plan.

SPOKANE COUNTY EMERGENCY SERVICES AGENCIES

AIRWAY HEIGHTS

Airway Heights, a suburban area, has a population of 4,600 in an area of 5.5 square miles. This represents a population density of 836.36 per square mile.

In the City of Airway Heights BLS the Airway Heights Fire Department provides first response. The Airway Heights Fire Department provides a tiered response with EMS transport provided by American Medical Response, an ALS ambulance. Northwest Medstar provides air ambulance service to the Airway Heights area.

CITY OF CHENEY

The City of Cheney, an urban area, has a population of 8,515 in area of 4.5 square miles. This represents a population density of 1892.22 per square mile.

In the City of Cheney, Cheney Fire Department provides a two tiered response .The Cheney Fire Department provides BLS first response with EMS transport provided by American Medical Response, an ALS ambulance. Northwest Medstar provides the air ambulance service.

DEER PARK AMBULANCE

Deer Park ALS Ambulance, a rural area, serves approximately 35,000 people in an area of approximately 600 square miles. This represents a population density of 58.33 per square mile.

If needed American Medical Response (AMR) ALS ambulance will rendezvous with Deer Park Ambulance. Deer Park Ambulance is dispatched by AMR and maintains up to six transport units with one paid 24 hour ALS duty

crew and a volunteer assigned duty roster for staffing three additional response tiers. Deer Park ambulance currently provides first response to the described "under served" wilderness 1 area (attachment A and B).

MEDICAL LAKE

The City of Medical Lake, a suburban area, has a population of 3,790 in an area of 4.3 square miles. This represents a population density of 881.39 per square mile.

In the City of Medical Lake BLS first response service is provided by the Medical Lake Fire Department. The Medical Lake Fire Department provides a two tiered response with EMS transport provided by American Medical Response, an ALS ambulance.

MILLWOOD

The Town of Millwood, a suburban area, has a population of 1,700 in an area of 0.7 square miles. This represents a population density of 2,428.57 per square mile.

In the Town of Millwood the Millwood Fire Department provides BLS first response with a secondary ALS response by Valley Fire. The Millwood Fire Department has a tiered response with EMS transport provided by American Medical Response, an ALS ambulance.

CITY OF SPOKANE

The City of Spokane, an urban area, has a population of 190,000 in an area of approximately 60 square miles. This represents a population density of 3,166.66 per square mile.

In the City of Spokane the Spokane Fire Department provides a multi-tiered system of BLS and ALS first response service. EMS transport is provided by the contract agency selected by the Spokane City Council or it will be a combination of contract transport provider and/or the Spokane Fire Department as designated by the Spokane City Council.

SPOKANE INTERNATIONAL AIRPORT

Spokane Airport Fire Department in conjunction with Spokane County Fire Districts 3 and 10 provide BLS service for the Spokane International Airport. They have a tiered response with EMS transport provided by American Medical Response, an ALS ambulance.

SPOKANE VALLEY (SCFD 1)

The Spokane Valley, a suburban area, has a population of 100,000 in an area of 78 square miles. This represents a population density of 1,282.05 per square mile.

In the area of Spokane County Fire District 1 (Spokane Valley Fire Department) BLS and ALS first response service is provided by the Spokane Valley Fire Department. They have a multi-tiered response with EMS transport provided by American Medical Response, an ALS ambulance. Dispatch is provided by the Combined Communication Center.

SPOKANE COUNTY FIRE DISTRICT 2

Spokane County Fire Protection District 2, a rural area, has a population of 1,100 in an area of 132.5 square miles. This represents a population density of 8.30 per square mile.

Spokane County Fire District 2 (SCFD2) provides BLS first response service to their district. SCFPD 2 has a two tiered response with EMS transport provided by two ambulance units. If SCFD 2 needs ALS rendezvous, American Medical Response, an ALS ambulance, provides transport. Northwest Medstar provides air ambulance service for SCFD 2.

SPOKANE COUNTY FIRE DISTRICT 3

Spokane County Fire Protection District 3, a rural area, has a population of 15,000 in an area of 565 square miles. This represents a population density of 26.54 per square mile.

Spokane County Fire District 3 (SCFD 3) provides BLS first response in their area. They have a tiered response with 3 different transport providers. An agreement has been reached with Lincoln County Fire District 1 BLS ambulance and American Medical Response ALS ambulance for a 14 square mile area in the Southwest corner of the district. SCFD 3 has reached an agreement with Whitman County Fire District 7 for BLS/ALS transport with ALS rendezvous (in the event they are not ALS) with American Medical Response in a 101 square mile area in the Southwest corner of the district. The remainder of SCFD 3 and the Town of Spangle have a tiered response by agreement with American Medical Response ALS ambulance

SPOKANE COUNTY FIRE DISTRICT 4

Spokane County Fire Protection District 4, a rural area, has a population of 35,000 in 330 square miles. This represents a population density of 106.06 per square mile.

Spokane County Fire District 4 (SCFD 4) provides BLS first response. They have a tiered response with two ALS transport agencies. Deer Park Ambulance provides ALS transport North of Woolard Road and American Medical Response ALS ambulance provides transport South of Woolard Road.

SPOKANE COUNTY FIRE DISTRICT 5

Spokane County Fire Protection District 5, a rural area, has a population of 3,500 in an area of 88 square miles. This represents a population density of 39.77 per square mile.

Spokane County Fire District 5 (SCFD 5) provides BLS first response in their area. SCFD 5 has a two tiered response with EMS transport provided by American Medical Response, an ALS ambulance.

SPOKANE COUNTY FIRE DISTRICT 8

Spokane County Fire Protection District 8, a rural area, has a population of 19,700 in an area of 110 square miles. This represents a population density of 179.09 per square mile.

Spokane County Fire District 8 (SCFD 8) provides BLS first response to their suburban and rural areas. SCFD 8 has a two tiered response with EMS transport provided by American Medical Response, an ALS ambulance. Fire District 8 responds within mutual and automatic aid response areas with City Fire, Fire District 1, Fire District 3, Fire District 11, or Spokane County wide Mutual Aid Agreements. Northwest Medstar provides air ambulance service to SCFD 8.

SPOKANE COUNTY FIRE DISTRICT 9

Spokane County Fire Protection District 9, a rural area, has a population of 36,000 in an area of 130 square miles. This represents a population density of 276.92 per square mile.

Spokane County Fire District 9 (SCFD 9) provides BLS and ALS first response to their suburban and rural areas. SCFD 9 has a two-tiered response with EMS transport provided by a private ALS ambulance selected by the district Fire Chief and the district Board of Commissioners. EMS patient transport providers can/may be non-contractual, contractual, or a combination of a contract transport provider and/or Spokane County Fire District 9 as designated by the district Fire Chief and the fire district Board of Commissioners.

Need: Spokane County Fire District 9 is currently a verified BLS service. The district is now providing 24 hour a day ALS service and is in the application process to verify as an ALS agency. The Spokane County min/max numbers have been changed with the local council submission of this document to reflect this change.

SPOKANE COUNTY FIRE DISTRICT 10

Spokane County Fire Protection District 10, a rural area, has a population of 9,000 in an area of 95 square miles. This represents a population density of 94.73 per square mile.

Spokane County Fire District 10 (SCFD 10) provides BLS first response to their rural district. SCFD 10 has a two tiered response with EMS transport provided by American Medical Response, an ALS ambulance. Northwest Medstar provides air ambulance service to SCFD 10.

SPOKANE COUNTY FIRE DISTRICT 11

Spokane County Fire Protection District 11, a rural area, has a population of 953 in an area of 71 square miles. This represents a population density of 13.42 per square mile.

Spokane County Fire District 11 (SCFD 11) provides BLS service to their district. SCFD 11 has a two tiered response system with EMS transport provided by American Medical Response, an ALS ambulance and Tekoa BLS Ambulance.

SPOKANE COUNTY FIRE DISTRICT 12

Spokane County Fire Protection District 12, a rural area, has a population of 680 in an area of 79 square miles. This represents a population density of 8.60 per square mile.

Spokane County Fire District 12 (SCFD12) provides BLS first response service to their district. SCFD 12 has a two-tiered response system with Spokane County Fire District 2 Ambulance, Tekoa Ambulance, and/or Rosalia Ambulance

SPOKANE COUNTY FIRE DISTRICT 13

Spokane County Fire Protection District 13, a rural area, has a population of 1,300 in an area of 22 square miles. This represents a population density of 59.09 per square mile.

Spokane County Fire District 13 (SCFD 13) provides BLS first response service to their district. SCFPD 13 has a two tiered response with EMS transport provided by American Medical Response, an ALS ambulance.

AMR SPOKANE SERVICE AREA

Emergency Transport – 911 Generated Requests for Transport

AMR Spokane's service area is in Spokane County and provides ALS level transport to the following areas: Primary areas of service include the west- side of the county (West Plains) east along the I-90 corridor to the Idaho border. This includes all of Fire District's 1, 8, 9, 10, 11 and 13. AMR will also provide primary transport service to portions of Fire District's 3, 4 and 5 as identified by their agreements with other transport providers. AMR provides back up transport to other areas of the county when requested by the fire district, Fairfield Ambulance or Deer Park Ambulance as needed. Service is provided to the cities of Medical Lake, Airway Heights, Cheney and Millwood through service agreements with these municipalities or the fire departments that provide service. Transport service is provided to the City of Spokane through a transport contract that expires in 2003.

Non Emergency Transport – Interfacility Trauma Transport

AMR Spokane provides non-emergency trauma transport to all areas of Eastern Washington and North Idaho. A service agreement exists with Northwest Med Star when their units are unable to fly due to inclement weather and/or requests for RN level care.

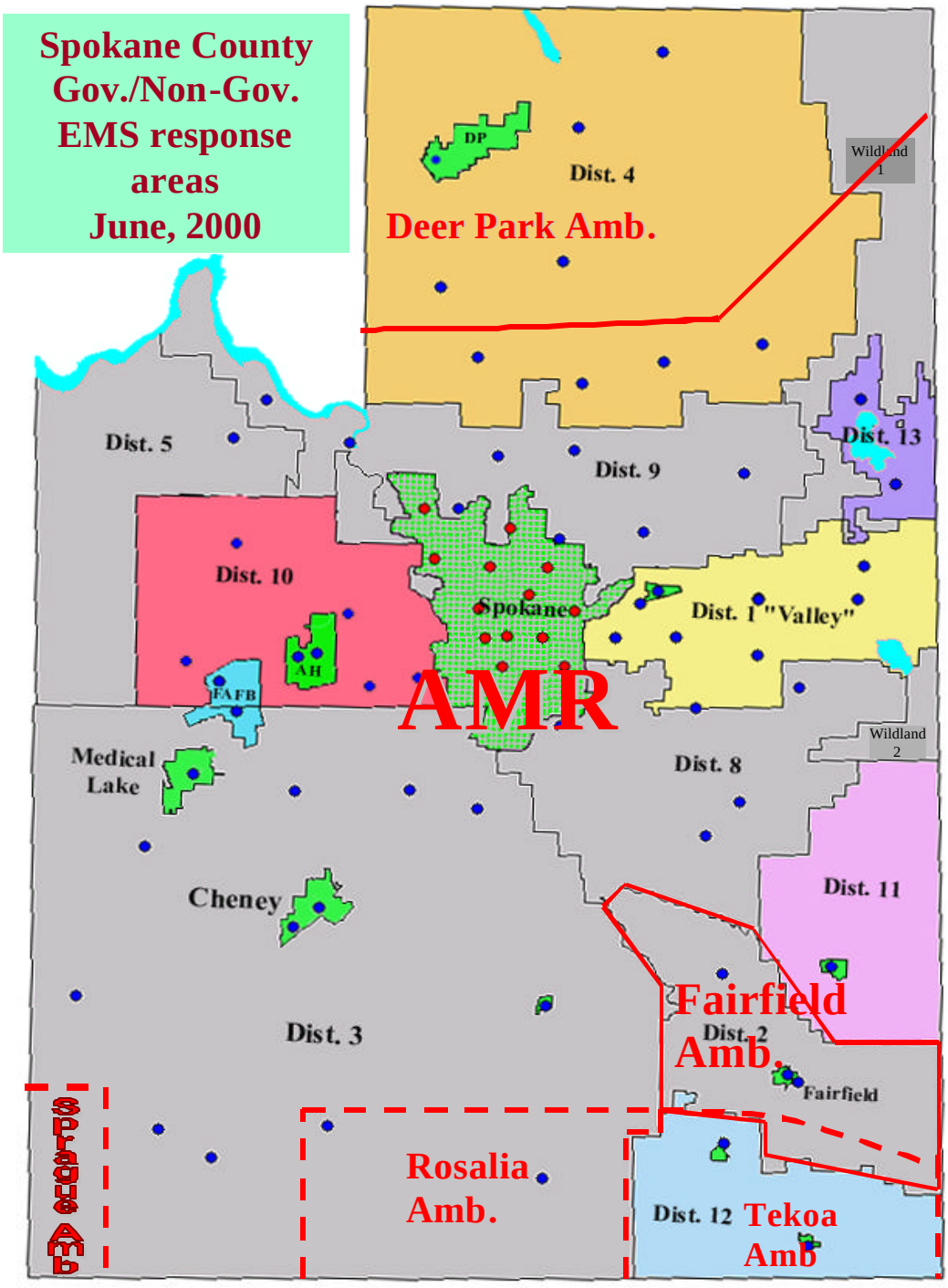
Ambulance Dispatch

Dispatch is accomplished by a fully integrated, computer assisted dispatch center that is electronically linked to the county's CCC in Spokane. AMR receives calls from this center, via computer, on all 9-1-1 requests for transport within the county. AMR is currently under contract with Deer Park Ambulance to provide dispatch services to their organization.

Northwest Medstar

(While min/max numbers for air transport is a State DOH issue the reference is included to ensure they are considered in our planning and operations.)

Northwest Medstar is a Critical Care Air Ambulance service, which is primarily located in Spokane, WA with a satellite base in Moses Lake. Medstar operates 24 hours per day, 7 days per week, and 365 days per year for rapid response for the East Region EMS Agencies and hospitals. Our RN/RRT team configuration gives the East Region a critical care team in addition to a ALS team. Medstar has three rotor wing aircraft, the EC 135, as well as two fixed wing aircraft, the King Air 200



- Identifies where stations are located.

WILDERNESS AREAS

There are two wilderness areas within Spokane County, one in the northeast section of the county (wilderness 1 on attachment A) and one in the southeast section of the county (wilderness 2 on attachment A) that are under served, that have limited adequate access, and that are state and private land. Ground and air ambulance respond to all wilderness areas in Spokane County, although there is no first response aid service.*

The north section, wilderness 1, is approximately 75 square miles that is bordered at the south by Spokane City, by District 9 to the west, by the Idaho state line to the east and to the north by the County border.

The Southern area, wilderness 2, is the north side of Mica Peak, is approximately 20 square miles that borders Fire District 8 on the west, District 11 to the south, District 1 to the north and the Idaho state line to the east.

NEED: The wilderness zones need to be incorporated into district/municipal boundaries as soon as the population density and development will allow.

The Spokane County EMS community and the bordering North Idaho EMS Communities need to develop dialogue for improvement of services in the wilderness zones.

RESPONSE TIMES

Non-Transport Agencies	No Times Recorded	Response Areas Urban	Suburban	Rural	Wilderness
Agency A	2	0	23	0	0
Agency B	0	0	0	2	0
Agency C	1	0	1	51	0
Agency D	1	1	10	7	0
Agency E	4	1	1	5	0
Agency F	0	5	12	6	0
Agency G	0	0	0	4	0
Agency H	0	0	5	0	0
Agency I	0	3	0	0	0
Agency J	0	0	0	1	0
Agency K	0	1	1	0	0
Agency L	0	192	0	0	0
Agency M	0	0	0	0	0
Agency N	0	0	0	0	0
Totals	8	203	53	76	0
Response Times		>8	>15	>45	ASAP
Runs Exceeding WAC		9	0	0	0
% WAC Compliant		**95.50%**	**100%**	**100%**	

Ground Transport

Agency O	12	159	114	94	0
Agency P	1	1	0	68	0
Agency Q	0	0	0	0	0
Totals	13	160	114	162	0
Response Times		>10	>20	>45	ASAP
Runs Exceeding WAC		25	2	0	
% WAC Complaint		**84.30%**	**98.20%**	**100%**	

Air Transport	302	27	46	208	26

NEED AND DISTRIBUTION OF SERVICES

Stevens County, located in northeastern Washington State, is 2,481 square miles in area. Lake Roosevelt forms the western border and the Spokane River along with Lincoln County form the southern border. British Columbia, Canada is to the north with two access routes. U. S. Route 395 and State Highway 25 run the full length of the County from north to south. East/west routes include State Highway 20, State Highway 231 and several County maintained routes. These two lane roads can be dangerous to travel in many areas, particularly in the winter. The terrain is hilly and mountainous, the Colville National Forest occupies a large area in the north and the Spokane Indian Reservation is in the south of the County. Elevations range from 7, 308 feet at the peak of Abercrombie Mountain in the north to a low of 1,290 along Lake Roosevelt in the South County.

A Stevens County Profile including; General County information, population change, city and town populations, population by race, State revenue distribution to County Governments, Real estate excise tax collections, County revenue expenditure, average monthly employment and total wages, Public assistance programs, Public K-12 schools, transportation and population by age and sex is attached. It is labeled "appendix A" and was downloaded from the web page of the Washington State Office of Financial Management.

All licensed EMS agencies currently operating within Stevens County are trauma verified. A map of agencies and their respective coverage areas is also provided and is labeled "appendix B". The following is a list of agencies.

LICENSED AGENCIES PROVIDING FIRST RESPONSE

Stevens County Fire District #1 (BLS, volunteer)
Marble First Response and Rescue (BLS, volunteer)
Stevens County Fire District #8 (BLS, volunteer)
Rice First Response (Stevens County Sheriff's Ambulance) (BLS, volunteer)
Northwest Alloys First Response (Stevens County Sheriff's Ambulance)(BLS, paid)
National Park Service (BLS , paid)

LICENSED AGENCIES PROVIDING AMBULANCE TRANSPORT

Stevens County Sheriff's Ambulance (BLS, volunteer)
Chewelah Rural Ambulance (BLS, volunteer)
Spokane Tribal Ambulance (BLS, volunteer)
Deer Park Ambulance (ALS, paid & volunteer)
Suncrest Ambulance (BLS, volunteer)
Affiliate Licensed Agencies
North West Alloys (on site) (BLS, paid)
49 Degrees North Ski Patrol (on site) (BLS & ALS, paid & volunteer)

UNLICENSED AGENCIES PROVIDING SUPPORT

Nordic Rescue (back country & low angle rescue)
Team Rescue (vehicle/equipment extrication)
Critical Incident Stress Management (counseling support)

DISPATCH SERVICES

Spokane Tribal Ambulance is dispatched by their ambulance/fire dispatch. Spokane Combined Communications Center dispatches Stevens County Fire District #1; they also dispatch Deer Park Ambulance via American Medical Response in Spokane. The Stevens County 911 Center in Colville dispatches all other agencies listed.

TIERED RESPONSE

A tiered response is dispatched within first response areas (see response area map). Transporting ambulance response outside of a first response area is not supported by a tiered effort unless mutual aid is requested by that ambulance service. The first response areas were formed by fire district boundaries, or by geographic relationship between ambulance agencies and first response agencies. If an ambulance agency could obviously arrive on scene, under normal conditions, before a first response agency, a tiered response is not dispatched. These areas are addressed under "evaluated needs".

ALS RENDEZVOUS

Northern Stevens County is not accessed by ALS rendezvous in a timely manner because of the geographic proximity to available ALS agencies. The nearest ground transporting ALS agency is 45 to 85 miles away in Deer Park. The nearest ALS helicopter-transporting agency is 75 to 120 miles away in Spokane.

Central Stevens County may rendezvous with ALS services either by ground from Deer Park, Spokane or Medstar helicopter service from Spokane in a timely manner.

Southeastern Stevens County is served by Deer Park Ambulance, which is ALS.

Spokane Tribal Ambulance and Chewelah Rural Ambulance serve Southwestern Stevens County. ALS rendezvous would be from Medstar in Spokane or Lincoln County Ambulance.

EVALUATED NEEDS PER AGENCY

Barney's/Orient Fire District #8 is in need of a crew strength increase of four to six additional first responders. Currently the First Responders from this Fire District are traveling to Colville for continuing education, which is a twenty to twenty five mile journey for some. An occasional visit from outside training sources would be quite beneficial. This fire district is also in dire need of light extrication equipment.

Marble First Response and Rescue is in need a four-wheel drive vehicle (they currently operate with a loner from the Sheriff's Ambulance). There is no extrication equipment north of Colville, so this is a priority also. They hope to upgrade to a BLS transporting agency within the next two years and then to an ILS transporting agency within four years.

Rice First Response (Stevens County Sheriff's Ambulance) is in need of four to eight additional First Responders. They are looking for a building to house their First Response vehicle. Light extrication is also an identified need.

Stevens County Sheriff's Ambulance is currently providing transport services for the entire Northern half of Stevens County. Six to ten additional EMT-B's are needed to staff the vehicle stationed in Kettle Falls. The large response area along with very long transport times places this service in great need of ILS training.

Chewelah Rural Ambulance is in need of eight to ten additional EMT-B's. They currently have several newly trained ILS crewmembers and would like to upgrade to an ILS verification. The nearest extrication source for this agency is Team Rescue from Colville or Fire District #1 to the south. Light extrication equipment is a need as well.

Spokane Tribal Ambulance is in need of additional crewmembers (EMT-B). They have been experiencing an increase in need for water rescue training and equipment as well as additional extrication equipment (hydraulic ram). Training is also a concern.

Fire District #1 is in need of additional extrication equipment to place in stations that serve Highways 395, 231 and 291. They would like to upgrade current First Responders to EMT-B and also all EMT-B's to ILS.

Deer Park Ambulance provides ALS transport services in Southeastern Stevens County including but not limited to Clayton, Deer Lake, Loon Lake, Springdale and Suncrest. They would like to train additional paramedics for growth.

IDENTIFIED UN-DERSERVED AREAS

An area in northwest Stevens County of approximately 100 square miles, between Barney's/Orient Fire District #8 and the response area of Marble First Response and Rescue, is currently without a first response agency. Ambulance transport is dispatched from Colville or Kettle Falls with a response time to the scene of fifteen to forty minutes.

Deep Lake/Aladdin area, the northeast corner of Stevens County, an area of approximately 80 square miles, is currently without a first response agency. This area is very active with outdoor activities including hunting, fishing, boating and camping. Marble First Response and Rescue is covering this area, but the response time would be greatly reduced with an agency in the immediate area.

Pend Oreille Lakes area, east of Colville fifteen to twenty eight miles, an area of approximately 65 square miles, is currently without a first response agency. This area is also very active with outdoor activities including hunting, fishing, boating, hiking and camping. Ambulance transport is dispatched from Colville with a response time to the scene of twenty to thirty five minutes.

Hunters/Fort Spokane area, the southwest corner of Stevens County, an area of approximately 115 square miles, is currently without a first response agency. This area is also quite active with outdoor activities including boating, hiking, hunting, fishing, jet skiing and camp ing. The National Park Service has both EMT-B's and First Responders who will respond in Park Service vehicles along Lake Roosevelt and surrounding area, however this is a seasonal source of first response. Ambulance transport is dispatched from Chewelah with a response time to the scene of twenty five to forty five minutes, or Spokane Tribal Ambulance with a response time to the scene of fifteen to twenty five minutes when available.

Waitts Lake/Deer Creek area, southwest of Chewelah, an area of approximately 70 square miles, is currently without a first response agency. This area is also quite active with outdoor activities including hunting, fishing, hiking and boating. Ambulance transport is dispatched from Chewelah with a response time to the scene of twelve to twenty five minutes.

IDENTIFIED UNDER-SERVED AREAS

The general area of Northport, Deep Lake, Marble, Onion Creek and Flat Creek in northeastern Stevens County lies thirty to forty minutes travel time from the nearest transport service, the Sheriff's Ambulance in Colville. This area would be better served by an additional ambulance service based in Northport or Marble.

The general area, in northwest Stevens County, south of Laurier and east of Orient including the Pierre Lake area, lies thirty to forty minutes travel time from the nearest transport service, the Sheriff's Ambulance in Colville. This area would be better served by an additional ambulance service based in the northern end of Fire District #8.

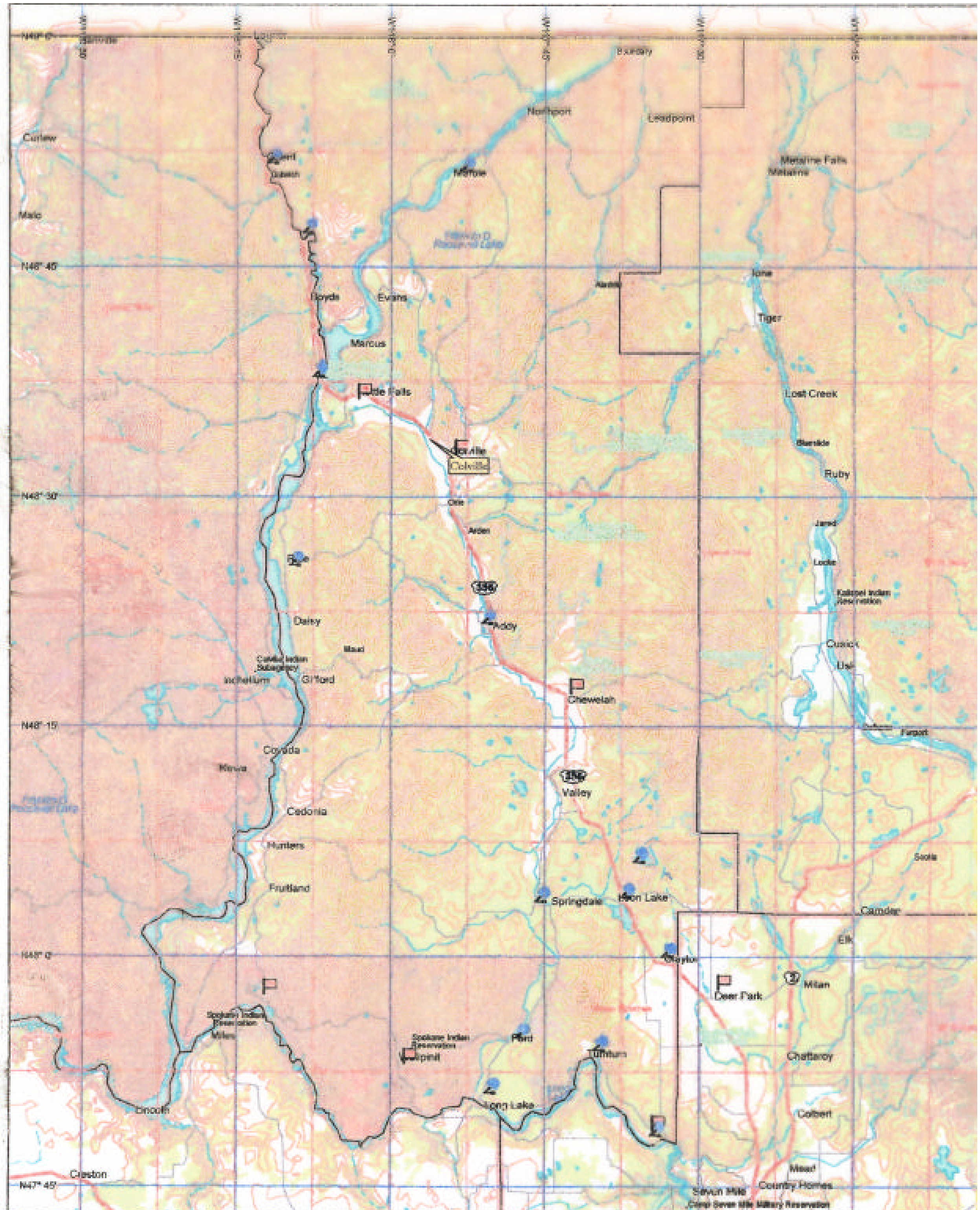
The general area of Loon Lake, Springdale and Deer Lake in southern Stevens County lies fifteen to twenty minutes travel time from the nearest transport service, Chewelah Rural Ambulance in Chewelah or Deer Park Ambulance. This is a very busy area along the Highway 395 corridor. This area would be better served by an ambulance service in the Loon Lake or Springdale area.

The general area of Rice, Gifford, and Hunters in southwestern Stevens County lies twenty-five to forty minutes from the nearest transport service, the Sheriff's Ambulance in Colville or Chewelah Rural Ambulance in Chewelah. This area would better served by an additional transport service based in the Hunters or Rice area.

MINIMUM/MAXIMUM RECOMMENDATIONS OF VERIFIED SERVICES

The East Region EMS & Trauma Care Council's recommendation to the Washington Department of Health for minimum and maximum numbers of trauma-verified prehospital services for Stevens County is:

Stevens	**Check if**	**Current**	**Minimum Number**		**Maximum Number**	
Services	**No Change**	**Status**	**Approved**	**Recommended**	**Approved**	**Recommended**
Aid - BLS		3	5	5	8	8
Aid - ILS		0	0	0	2	2
Aid - ALS	X	0	0	0	0	0
Amb - BLS		3	3	3	4	4
Amb - ILS		0	0	0	2	0
Amb - ALS		0	1	1	2	2



3-D TopoQuads Copyright © 1999 DeLorme Yarmouth, ME 04096 |—| 4 mi Scale: 1 : 600,000 Detail: 8-4 Datum: WGS84

WHITMAN COUNTY
EMERGENCY MEDICAL SYSTEM & TRAUMA COUNCIL

DISTRIBUTION OF LICENSED AND VERIFIED EMS SERVICES

AREA PROFILE

Whitman County is located in the heart of the Palouse Region of Southeastern Washington. The County population is 41,900. The economy is based largely on agriculture. Washington State University, located in Pullman draws major influxes of people into the county during the school year. It also draws large numbers of people during concerts and sporting events. The south, southwestern, and west parts of the county contain vast areas of scabland and rocky canyons around the Snake River and channeled scablands where access by vehicle is limited. The County has 8 state highways running through it with the major one being SR195 connecting Spokane with the Lewiston/Clarkston area. The land area in Whitman County is 2007.6 square miles (1,284,887 acres). The population density of people per square mile is 20.9. The percentage of the county population over the age of 65 was 8.63% in 1998. The median income in 1998 was $30,208. The county is bordered to the north by Spokane County, to the south by the Snake River, to the west by Adams County, and to the east by the Idaho State border.

Whitman County EMS agencies as part of the E-911 system designated response areas for first response and transport agencies so that no overlap or omission of area occurred within the county. We are dispatched by alphanumeric pagers from our county dispatch (Whitcom). Since then we have found that these pagers have not met our needs as some agencies can not receive pages. This problem has been identified and options are being studied to remedy this situation. Dispatching is currently accomplished by a variety of methods until a workable county system can be installed.

Currently, for each EMS call to service one first response and one transport agency are dispatched according to the service areas identified on the enclosed maps using a tiered response system. Some areas within the county are not tiered (approximately 25%) where the transport agency is also the first response agency.

PRE-HOSPITAL PLANNING AREA:

Land area 2007.6 square miles
Land acres 1,284,887
Total population:
County 6738
Incorporated 36,162
Population density 20.9 per square mile
19 Licensed / verified EMS agencies
1 Non-verified EMS agency

LICENSED EMS AGENCIES:

TOWN OF ALBION FIRE & EMS 38M16
City Fire Dept.
Volunteer
1 BLS Verified Ambulance
Map Code Albion Ambulance Transport Map AAMB on first response map
7 EMT-B's (4 PTL certified)

Albion Fire & EMS services an incorporated town of 685 people. They just recently upgraded from Aid service to a Transport service. They also service an area outside the city limits within Rural Fire District #11.

COLFAX FIRE & RESCUE 38X04
Private/non-profit
Mainly volunteer / 4 paid personnel
2 BLS Verified Ambulances 1 Rescue
Colfax Ambulance on transport map, CAMB on first response map
24 EMT-B's (4 I.V. & PTL certified) 11 First Responders
1 Paramedic

Colfax Fire & Rescue services an incorporated town of 2880 people. They also provide transport service to a large portion of southwestern Whitman County. Upgrading to ILS or ALS is currently underway.

CITY OF COLFAX 38M17
Municipality
Paid/Volunteer
1 BLS Verification pending Aid Vehicle
City Limits of Colfax
See Description Above

WHITMAN COUNTY FIRE DISTRICT #14 COLTON / UNIONTOWN 38D14
Fire District
Volunteer
2 BLS Verified Aid Vehicles
Map Code CUE on first response map See also Lewiston Ambulance on transport area map
12 EMT-B's (1 I.V. & PTL certified) 6 First Responders

Fire District #14 services two incorporated towns located approximately 3 miles apart. Colton has 370 people and Uniontown has 330 people. They also service an area within Fire District #14. Fire District #14 utilizes Pullman Ambulance and Lewiston Ambulance for transport.

WHITMAN COUNTY FIRE DISTRICT #11 DIAMOND
Fire District
Volunteer
1 BLS Aid Vehicle UNVERIFIED
Map Code CAEDE, CADE on first response map
1 EMT-B 2 First Responders

Diamond Fire Department services an unincorporated town of approximately 80-100 people. They are currently working on becoming a licensed agency. Funding has prevented them from acquiring the necessary minimum equipment to become licensed and verified. Colfax Ambulance provides transport service.

ENDICOTT EMERGENCY MEDICAL RESPONSE 38D06
Fire District
Volunteer
1 BLS Verified Aid Vehicle
Map Code CAEE, CAEDE on first response map
6 EMT-B's (3 PTL certified)

Endicott Emergency Medical Response services an incorporated town of 351+ people. They also service an area outside the town within Fire District #6 and assist with Diamond Fire in FD #11. Colfax Ambulance provides transport service for Endicott.

WHITMAN CO. HOSPITAL DISTRICT #2 GARFIELD AMBULANCE 38X02
Hospital District
Volunteer
1 BLS Verified Ambulance
Map Code GAMB, GAOE, GAFE, GAPE, GASE on first response map (see also Garfield Ambulance on transport map)
17 EMT-B's (5 PTL certified, 2 I.V.)

Garfield Ambulance services an incorporated town of 592+ people. They also service an area outside the town within several fire districts.

WHITMAN COUNTY HOSPITAL DISTRICT #2 FARMINGTON EMS 38X02
Hospital District
Volunteer
1 BLS Verified Aid Vehicle
Map Code GAFE on first response map
3 EMT-B's 2 First Responders

Farmington EMS services an incorporated town of 150+ people. Garfield Ambulance provides transport service to Farmington.

WHITMAN COUNTY FPD #5 LAMONT 38D05
Fire District
Volunteer
1 BLS Verified Aid Vehicle
Map Code LESPA on first response map
2 EMT-B's 5 First Responders

Lamont EMS services an incorporated town of 85 people. Sprague Ambulance provides transport service to Lamont from Lincoln County. Lamont has just recently become a licensed and verified service.

LACROSSE RESCUE 38M06
Fire District
Volunteer
1 BLS Verified Aid Vehicle
Map Code CALE on first response map
6 EMT-B's (1 I.V. tech) 7 First Responders

Lacrosse Rescue services an incorporated town of 380 people. They also service a large area outside the city limits within fire district #6. Colfax Ambulance provides most of the transports for Lacrosse however, Washtucna Ambulance is sometimes utilized from outside the county when there are incidents near the Adams County line or for mutual aid.

MALDEN VOL. FIRE & EMC 38M07
City Fire Dept.
Volunteer
1 BLS Verified Aid Vehicle
Map Code RAME on first response map
4 EMT-B's 6 First Responders

Malden services an incorporated town of 265 people. They do not provide service outside the city limits of Malden unless requested for mutual aid. Rosalia Ambulance provides transport for Malden EMS.

OAKESDALE FIRE DEPT. 38M08
City/Fire District Combination
Volunteer
1 BLS Verified Aid Vehicle
Map Code TAOE, RAOE, GAOE on first response map
5 EMT-B's (1 PTL) 7 First Responders

Oakesdale Fire Dept. services an incorporated town of 445 people. They also provide service outside the city limits within their fire district. Rosalia, Tekoa, and Garfield Ambulances provide transport service.

PALOUSE EMS 38D04
Private/Non-Profit
Volunteer
1 BLS Verified Aid Vehicle
Map Code GAPE, PAPE on first response map
5 EMT-B's 4 First Responders

Palouse EMS services an incorporated town of 985 people. They also provide service outside the city limits within fire district 4. Pullman and Garfield Ambulances provide transport service to Palouse.

PULLMAN FIRE SERVICES 38M10
City Fire Dept.
Paid Service
3 ILS Verified Ambulances 1 Rescue
Map Code Pullman Ambulance on transport map PAPE, PAMB on first response map
6 EMT-P, 2 EMT-I, 21 EMT-B, 11 First Responders

Pullman Fire Services provides EMS to an incorporated town of 25,630. They also provide service to the town of Palouse and fire district #12. They are currently very close to becoming a verified ALS service and will bring an additional 2 EMT-P's on board in early 2000.

ROSALIA VOLUNTEER FIRE DEPT. 38M11
City/Fire District Combination
Volunteer
2 BLS Verified Ambulances 1 Rescue
Map Code Rosalia Ambulance on transport map RAME, RAMB, RASJE, RAOE, RASE on first response map
5 EMT-B, 3 EMT-IV, 3 EMT-I, 1 EMT-P, 3 First Responders

Rosalia Ambulance provides service to an incorporated town of 644+ people. They also provide transport service to St. John, Malden, Oakesdale, Steptoe, and southern Spokane County. They are currently BLS however, could become ILS in the future. They also have a Paramedic living in town to respond on part of their calls.

WHITMAN COUNTY FIRE DISTRICT #12 38D12
Fire District
Volunteer
1 BLS Verified Aid Vehicle
Map Code
7 EMT-B's 4 First Responders

Fire District 12 provides first response coverage for the area designated on the first response map code PAMB. Pullman will be the primary transport agency.

WHITMAN COUNTY FIRE DISTRICT #11 38D11
Fire District
Volunteer
1 BLS Verified Aid Vehicle
Map Code CASE, RASE, GASE on first response map
2 EMT-B, 1 EMT-IV, 6 First Responders

Currently the only agency under 38D11 is Steptoe Fire Dept. In the future, we hope to bring Diamond under the 38D11 license. Steptoe Fire Dept. services an unincorporated town of approximately 100 people and services the northern portion of district 11 and the southern portion of fire district 7. Colfax, Rosalia, and Garfield Ambulances provide transport service for Steptoe.

ST. JOHN VOLUNTEER FIRE DEPARTMENT 38M12
City/Fire District Combination
Volunteer
1 BLS Verified Aid Vehicle
Map Code RASJE, CASJE, CADSJ on first response map
7 EMT-B 3 First Responders

St. John services an incorporated town of 555+ people. They also service a large area within their fire district. Colfax and Rosalia provide transport service to St. John. They are in need of a Hurst Tool and would like to get some of their EMT's I.V trained.

TEKOA COMMUNITY AMBULANCE 38X03
Private/Volunteer Association
Volunteer
2 BLS Verified Ambulances
Map Code Tekoa Ambulance on transport map TAOE, TAFE on first response map
6 EMT-B's (all PTL) 2 First Responders

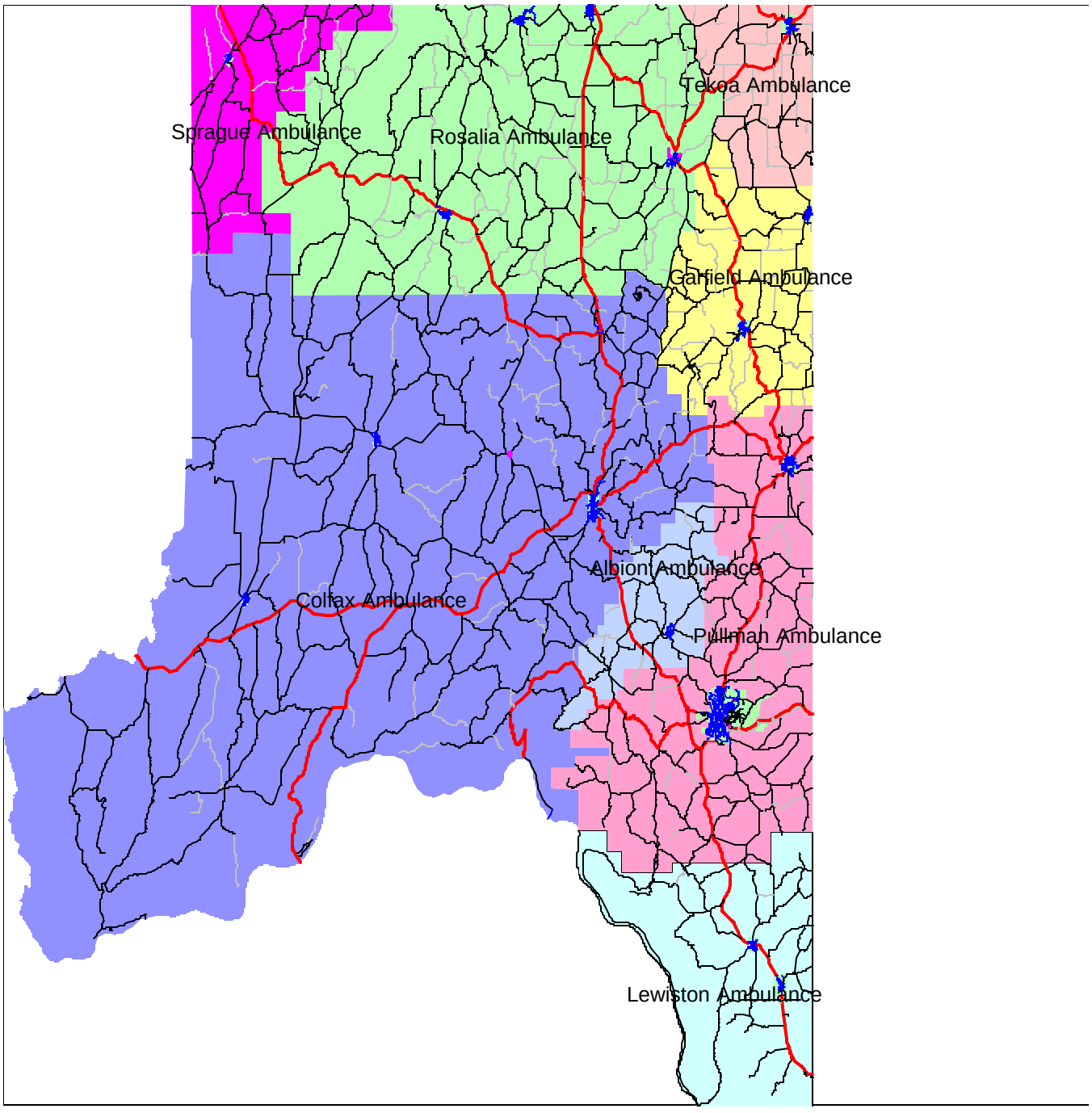
Tekoa Ambulance services an incorporated town of 815 people. They also service an area outside the city limits and provide transport service to Oakesdale and Farmington.

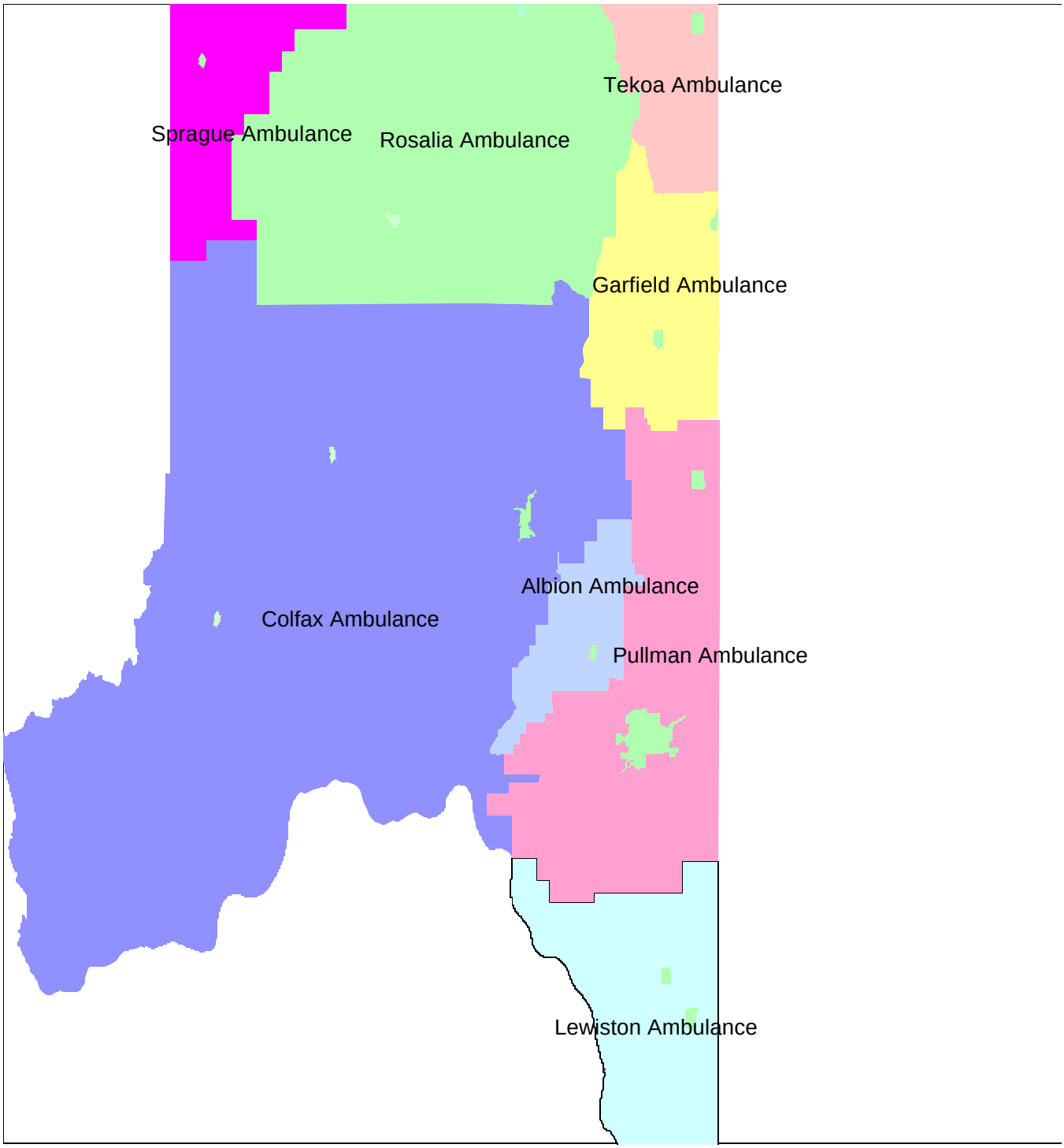
WASHINGTON STATE UNIVERSITY FIRE DEPARTMENT 38S01
Municipal
Paid/Volunteer
2 BLS Verified Ambulances 1 BLS Verified Aid Vehicle
Map Code WSUA on both transport and first response maps
21 EMT-B all combi-tube/defib certified

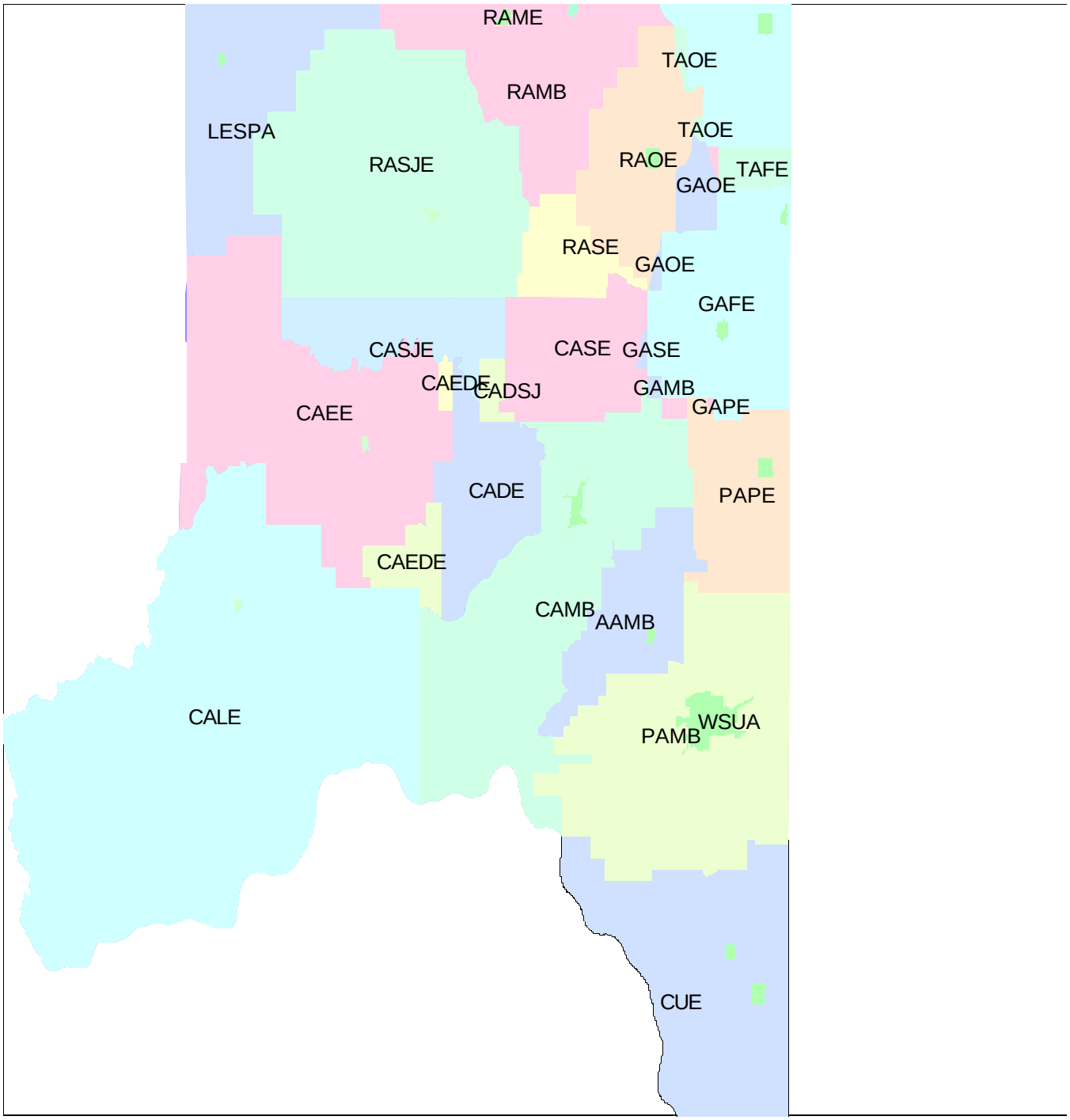
WSU Ambulance services the campus of Washington State University. They are available to respond outside the campus if needed.

WHITMAN COUNTY PLAN

The Whitman County EMS & TC Council do not see the addition of any new agencies into the county in the next 5 years. This is due to the fact that all of the towns with sufficient enough people to support a service currently have one in place. Currently, Whitman County meets the minimum response time standards with the services now in place. We do see a need for upgrading the level of service for some of our agencies. This process has already started and is ongoing. Colfax Ambulance and Rosalia Ambulance have already started moving toward ILS service. These services will, in the future, probably upgrade their licensure to ILS. Whitman County would see any influx of funding to be used in upgrading level of service and equipment.


Tekoa Ambulance
Sprague Ambulance
Rosalia Ambulance
Garfield Ambulance
Albion Ambulance
Colfax Ambulance
Pullman Ambulance
Lewiston Ambulance

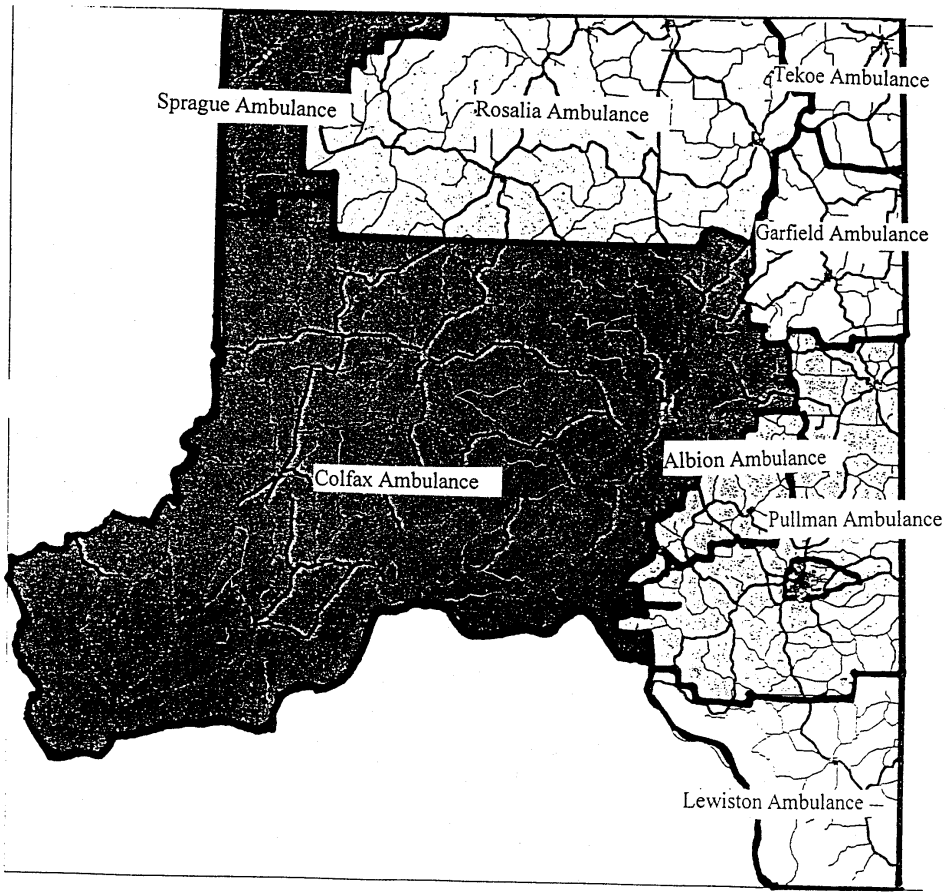

Tekoa Ambulance
Sprague Ambulance
Rosalia Ambulance
Garfield Ambulance
Albion Ambulance
Colfax Ambulance
Pullman Ambulance
Lewiston Ambulance



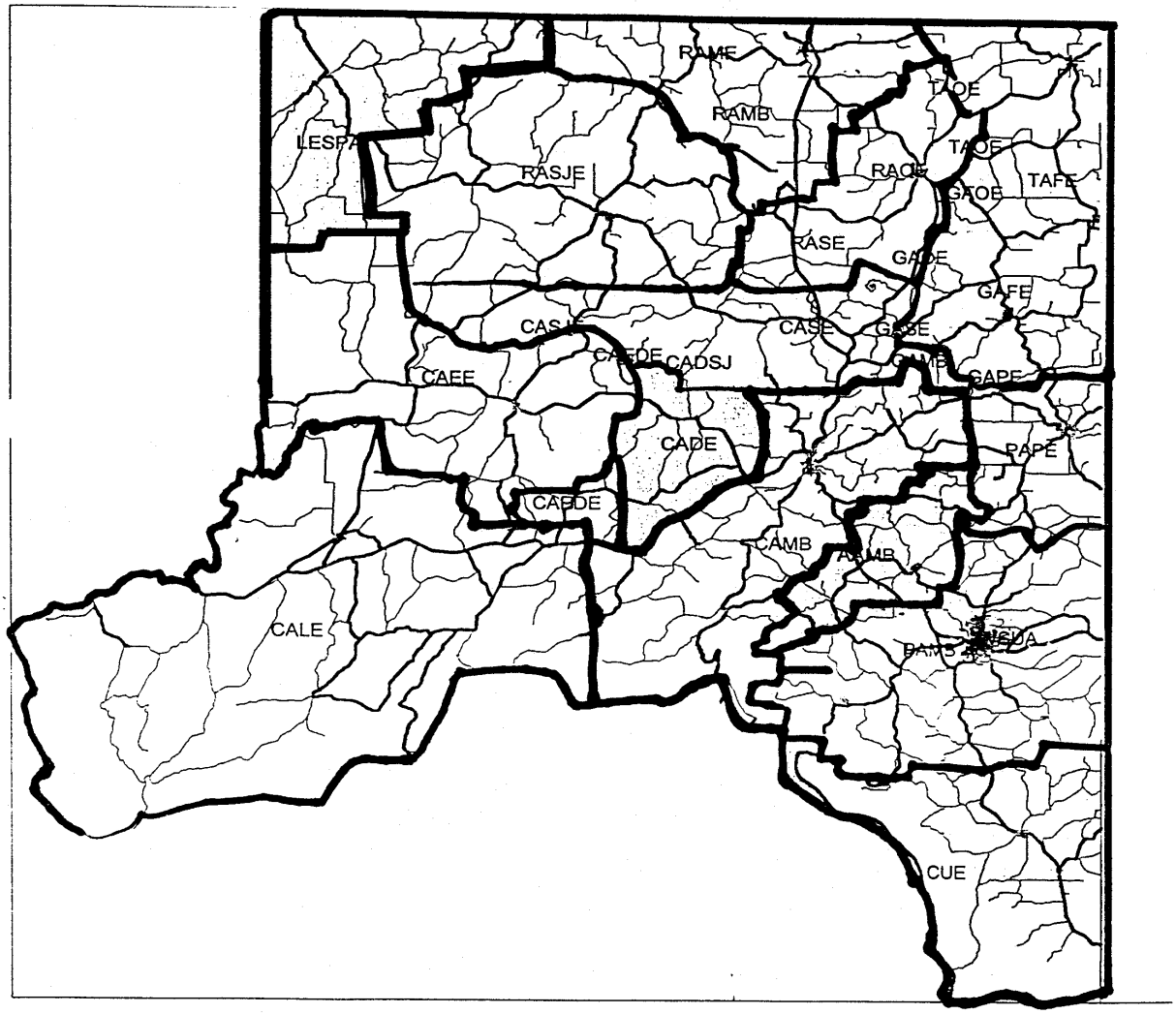
The codes listed on this map reflect the agency that will be responding and the response area. You may refer back to the narrative of the prehospital services on pages 87-93 for cross referencing.

Rosalia Amb. = RAME, RAMB, RASJE, RAOE, RASE
Tekoe Amb. = TAOE, TAFE
Colton/Union Town = CUE
Whitman FD #11 = CAEDE, CADE
Whitman Hosp. Dist. #2 (Farmington) = GAFE
Lacrosse Rescue = CALE
WSU Amb. = WSUA
St. John FD = RASJE, CASJE, CADSJ
Oakesdale = TAOE, RAOE, GAOE
Palouse EMS = GAPE, PAPE
Whitman Hosp. District #2 (Garfield)
CAMB, GAOE, GAFE, GAPE, GASE
Malden = RAME

WHITMAN COUNTY
RESPONSE AREA MAP
TRANSPORT SERVICES



WHITMAN COUNTY
RESPONSE AREA MAP
AID SERVICES



D.2. STRENGTHS AND WEAKNESSES: *Discuss the strengths and weaknesses of the existing prehospital service delivery system.*

Strengths

1) The East Region's most important strength in the prehospital arena is its EMS providers and their dedication to saving lives. As stated earlier, approximately 86% of all prehospital providers in this region are volunteers. Added to that, each County EMS/TC Council (excluding Adams County) has gone above and beyond the call of duty in the development and implementation of East Region EMS and Trauma System. Below is a short list of their accomplishments:

- They have all volunteered their time and energy into the development of the Needs and Distribution of Services reports included in this chapter.
- They have developed County Operating Procedures at the request of the Regional Council.
- They have encouraged their prehospital agencies to participate in the regional data collection program.

2) The improvement of an EMS system is based on the knowledge and experience that can be documented and demonstrated through patient care. A strength of the verified services in the East Region is the production of quantifiable, verifiable data in the form of the prehospital *Collector* to validate processes and procedures that are being done, should be done, or should stop being done in the prehospital setting. Currently the East Region is collecting in excess of 95% of all qualified trauma runs and forwarding that data to the Department of Health to be combined with data from other regions of the state.

Weaknesses

Retention and Retainability

1) Retainability in the rural EMS and trauma care prehospital agencies, both aid and ambulance services, is identified as a major problem in providing quality patient care. The East Region's Needs and Distribution of Services reports for the nine counties of the region also identify retainability as an issue being dealt with on a daily basis. The main reason this is such an issue in the East Region is because approximately 86% of all prehospital providers are volunteers, most with families and other job responsibilities.

The Training and Education Survey (addendum) identifies that during a five-year period 312 providers that left their respective agencies during the last five years. The information also reflects that those same agencies had 337 EMS providers join their agencies during that same five-year period. Garfield County had only 3 providers leave their agency but was able to recruit 8 providers to replace those that left. Spokane County, as expected, lost 128 EMS providers during the five-year period, but replaced 126 of them with new employees.

The number one reason for providers leaving their agencies was because they were moving out of the response area. Other reasons which rated very high in the survey for loss of providers were: 1) No time for EMS; 2) Family; 3) Present Job; 4) Better Job; and 5) Burnout. It is interesting to note that only one person left because of the new written exam. Four providers left because of internal politics and four others felt that there were too many requirements for certification. Eight providers left because they felt there was too much CME and 4 because of too much OTEP.

2) As mentioned above, the strength of an EMS system is the knowledge of doing the correct procedure in patient care. The weakness is leaving the choice of defining the correct procedure to the person with the loudest voice or the strongest fist banging on the table. Such decisions should be made using good

data (data before care). The changes that are to be instituted in prehospital data collection (July 1, 2001) will decrease the essential data required to make future decisions on patient care in the East Region.

3) Trauma verification has improved provision of patient care tremendously for the trauma patient. The weakness is and continues to be adequate funding for disposable supplies, durable equipment and capital items in support of the trauma care endeavor. Specifically the East Region has a plethora of small volunteer services providing trauma care on the rural county roads, state highways and in the fields. These agencies have very limited funding, and in some cases, no funding other than donations from the community. Supplemental funding through state grants and most recently regional grants is essential for their continued operation.

D. 3. DEMOGRAPHICS: *Identify specific demographics of the region that may drive the expansion of the existing prehospital personnel and training personnel and training needs such as population by age and gender.*

- Demographics have been identified in parts C (Prehospital EMS & Trauma Services) and D (Distribution of Services) of this section of the plan.

D.4. GOALS, OBJECTIVES, STRATEGIES AND PROJECTED COSTS: *Include long and short-term goals to improve the overall verified Prehospital EMS and Trauma Service response in the region.*

The goal, objective and strategies listed below are an example of what we want to put into the plan. The goal is long term, the objective tells why we want all agencies in the east region to be verified, and the strategies indicate how the goal will be accomplished.

GOAL I. All Licensed Prehospital Agencies In The East Region Shall Be Verified.

A. Ensure that all prehospital agencies within the region are working within the East Region EMS and Trauma System.

a. If funding becomes available the Regional Council will provide mini grants for EMS and trauma equipment as recommended by the agency and its County EMS/TC Council.

i. During FY 01 the Regional Council provided $6,500 in mini-grants to prehospital agencies that participated in the regional data collection program and had no more than 2 paid employees. If funding is available either through the council or through outside funding, this program will continue. Projected costs of this program are dependant on available funding.

b. The Regional Council will encourage all prehospital agencies with identified needs to apply for the Department's Needs Grants, when appropriate.

i. Projected Costs: Based on past experience, the needs of rural EMS agencies could exceed $200,000 annually. It is difficult to identify projected cost for this strategy.

ii. The Regional Council will encourage prehospital agencies to seek outside funding for any needs associated with verification. This may include equipment and training as well as other identified needs.

iii. Projected Costs: Contract Development and Administration
$ 702
Volunteer In-kind Costs (10 volunteers x 6 hours x $15/hr x 8 counties)
$7,200
Regional Council Costs for Adams County
900

Projected Annual Cost
$8,802
Projected Biennial Cost
$17,604

GOAL II: Continue Collecting Adequate Data To Ensure Proper And Correct Trauma Care In The Future.

A. Collect all trauma data generated by trauma patient care in the East Region.

- *I*t is the intent of the East Region to meet any WAC revisions for trauma data collection imposed by the Department of Health in addition to the East Region's trauma data collection process.

- Continue trauma data collection through the county data collection sites using the Washington State Prehospital *Collector* software or other software approved by the Department of Health and the East Region Data Committee.
- Transport agencies will provide to the hospitals those data points required in the revised hospital *Collector* software.

Projected Costs: No additional fees or costs are associated with continuing the current process of using the approved prehospital *Collector* software. It is undetermined at this point what the transition of providing data to the hospitals will cost in terms of prehospital agencies and hospitals.

GOAL III: All Licensed Agencies Become Or Remain Verified

A. To provide trauma care and transport services in all areas of the region 100% of the time.

B. To provide adequate supplies, equipment and capital items to all currently verified prehospital agencies or those agencies that still need to become verified.

- The Regional Council will do a survey of the prehospital agency needs of those currently verified and those agencies that still need to become verified. The survey will also include questions on current funding sources and additional opportunities.

- The East Region will work with the Department of Health and other agencies to resolve the disparity between required equipment and supplies and availability of those items.

Projected Costs: FY 02 Prehospital Needs Grants Applications reflect project needs of just under $200,000.

Adams	Check if	Current	Minimum Number		Maximum Number	
Services	No Change	Status	Approved	Recommended	Approved	Recommended
Aid - BLS		**0**	**4**	**0**	**4**	**0**
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	2	2	2	2	2
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

The Regional Council is unsure why the Adams County DOH approved min/max recommendations for verified services shows min/max of 4 BLS Aid services. Adams County has always had only <u>two (2) BLS verified ambulance services</u>. The Council requests approval of the above min/max numbers.

Asotin	Check if	Current	Minimum Number		Maximum Number	
Services	No Change	Status	Approved	Recommended	Approved	Recommended
Aid - BLS		**0**	**1**	**0**	**1**	**0**
Aid - ILS		**1**	**0**	**1**	**0**	**1**
Aid - ALS		**0**	**1**	**0**	**1**	**0**
Amb - BLS	X	0	0	0	0	0
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	1	1	1	1	1

We believe that the confusion on the Asotin County min/max numbers has to do with the agency training their providers to Paramedic status. The agency itself has been verified as an ILS Aid service. <u>The County Council has recommended that the min/max numbers reflect 1 ILS Aid service</u>. The Regional Council has adopted these recommendations and request approval by the DOH. The 1 – ALS Ambulance service is located in Lewiston, Idaho.

Ferry	Check if	Current	Minimum Number		Maximum Number	
Services	No Change	Status	Approved	Recommended	Approved	Recommended
Aid - BLS	X	0	0	0	0	0
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	2	2	2	2	2
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

No change in recommended min/max numbers for Ferry County.

Garfield	Check if	Current	Minimum Number		Maximum Number	
Services	No Change	Status	Approved	Recommended	Approved	Recommended
Aid - BLS	X	0	0	0	0	0
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	1	1	1	1	1
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

There has been no change in the Garfield County min/max recommendations for verified services.

Lincoln Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	2	2	2	2	2
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	6	6	6	6	6
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	0	0	0	0	0

There has been no change in the Lincoln County min/max recommendations for verified services.

Pend Oreille Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	7	6	6	7	7
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	3	2	2	3	3
Amb - ILS	X	0	0	0	1	1
Amb - ALS	X	0	0	0	0	0

There has been no change in the Pend Oreille County min/max recommendations for verified services.

Spokane Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS		**13**	**14**	**13**	**14**	**13**
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	3	3	3	3	3
Amb - BLS	X	1	1	1	1	1
Amb - ILS	X	0	0	0	0	0
Amb - ALS	X	2	2	2	2	2

A few years ago, Spokane County recommended the change in min/max number to 13 due to the loss of one of their Aid services. They have requested that the current recommended min/max numbers reflect the change <u>from 14 to 13 verified Aid services</u>.

Stevens Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS		**3**	**2**	**5**	**9**	**8**
Aid - ILS		**0**	**0**	**0**	**0**	**2**
Aid - ALS	X	0	0	0	0	0
Amb - BLS		**3**	**4**	**3**	**8**	**4**
Amb - ILS		0	0	0	0	0
Amb - ALS		**0**	**0**	**1**	**0**	**2**

The changes in the Stevens County min/max numbers are also reflected in the county's Needs and Distribution of Services. The Stevens County Council has recommended these changes and the Regional Council has adopted them. The Council requests approved as submitted.

Whitman Services	Check if No Change	Current Status	Minimum Number		Maximum Number	
			Approved	Recommended	Approved	Recommended
Aid - BLS	X	11	10	10	13	13
Aid - ILS	X	0	0	0	0	0
Aid - ALS	X	0	0	0	0	0
Amb - BLS	X	6	8	8	13	13
Amb - ILS	X	1	1	1	5	5
Amb - ALS	X	1	1	1	2	2

No change in Whitman County min/max recommendations for verified services.

1. CURRENT STATUS*: current status of regional PCPs and COPS*

The Prehospital & Transportation Committee has reviewed all of the Regional Patient Care Procedures (PCPs) during FY 00 and 01. PCPs #1 – 6 have been approved by the Department of Health and are included in the addendum section of this document. PCP #7 – Helicopter Response, has been reviewed and revised a number of times during the past year and was actually adopted by the Regional Council on June 13, 2001. The 1996 version of this document is the approved PCP. The new PCP #7 is being included in this document as a draft until the Department of Health approves it.

Regional Patient Care Procedures

Patient Care Procedures as defined in WAC are written operating guidelines adopted by the regional EMS/TC council, in consultation with local EMS/TC councils, emergency communications centers and the MPDs, in accordance with statewide minimum standards. The Patient Care Procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients shall be consistent with the transfer procedures in chapter 70.170 RCW.

In the East Region, the established policy allows for newly developed and/or revised Regional Patient Care Procedures to be mailed to all local EMS/TC councils, Medical Program Directors, and communications centers, as well as Regional Council members and alternates. Recommended changes are submitted to the Regional office, and the process begins all over again until the Regional Council adopts a Regional Patient Care Procedure. At that time, the document is forwarded to the DOH for review and approval.

Regional Patient Care Procedures	**Description**
PCP #1	Dispatch of Medical Personnel
PCP #2	Response Times
PCP #3	Triage & Transport
PCP #3A	Triage & Transport of Pediatric Patients
PCP #3B	Triage & Transport of Medical and Non-Trauma Patients
PCP #4	Interfacility Transfer
PCP #5	Medical Group Supervisor at the Scene
PCP #6	EMS/Medical Control Communications
PCP #7	Helicopter Response (1996 version is approved)

County Operating Procedures

County Operating Procedures (COPs) are developed in much the same way as Regional Patient Care Procedures. They are developed at the county level and should include the same provider involvement as listed in WAC 246-976-960 (1) (g) as for regional Patient Care Procedure development. County EMS/TC councils, in conjunction with Medical Program Directors and communications centers, approve the procedure and forward it to the Regional Council, where the Prehospital & Transportation Committee reviews the document. If the Prehospital & Transportation Committee approves the document submitted, it is then sent forward to the Regional Council for adoption, or returned to the county council for further revisions. Once adopted by the Regional Council, the COPs are then forwarded to the Department of Health for review and approval. Once the document has been approved by the Department, it becomes an official part of that particular Regional PCP and is included in the Regional PCP Manual.

The Regional Council has charged each of its nine county EMS/TC councils to develop, review, revise, and once adopted by the Regional Council and approved by the Department of Health, implement County Operating Procedures. These procedures outline how the county will implement regional Patient Care Procedures.

E.2. STRENGTHS AND WEAKNESSES – *Discuss the strengths and weaknesses of the current system and include an assessment of additional needs within the region.*

Strengths

Regional PCPs have given counties a standard procedure to follow when there is no County Operating Procedure. These documents, along with County Protocols, provide direction to prehospital providers working within the EMS and Trauma System.

Weakness

It appears that in some cases county EMS/TC councils have misunderstood the intent of County Operating Procedures (COPs), which is to add specificity to Regional Patient Care Procedures specific to the county itself. It will be necessary for the Regional Council, through its Prehospital & Transportation Committee, to work closely with county EMS/TC Councils to provide education on COPs.

E.3. DEMOGRAPHICS: *Identify specific demographics of the region that drive Patient Care Procedure development in the region.*

- Demographics have been identified in parts C (Prehospital EMS & Trauma Services) and D (Distribution of Services) of this section of the plan.

E.4. GOALS, OBJECTIVES, STRATEGIES AND PROJECTED COSTS – *to improve the PCPs and COPS*

GOAL I: Address Continuation Of The East Region Trauma System Through Regional Patient Care Procedures And County Operating Procedures.

A. Continue to develop, review, revise, and update regional Patient Care Procedures as needed.

a. Regional PCPs shall be reviewed as directed by contract and/or need by the Prehospital & Transportation Committee on an annual basis.

b. Cost for this project is based on volunteer hours of 120 @ $15/hr. totaling $1,800.

B. **Encourage county EMS/TC councils to continue to develop, review, revise, and update County Operating Procedures following the criteria established in the Regional Patient Care Procedures.**

a. Written agreements between the region and the county EMS/TC councils will have specific deliverables relative to the review of County Operating Procedures.

b. **Cost for this project** is based on county and regional volunteer time of approximately 153 hours @ $15 hr. totaling $2,295.

C. Continue to encourage MPD participation in county EMS/TC Council activities, specifically in the development, review, revision and updating of County Operating Procedures.

D. Review County Operating Procedures to determine which ones are actually COPs and which ones are not.

a. The Prehospital & Transportation shall accomplish the review during FY 02.

b. Cost for this project shall be based on committee volunteer hours of 270 hours @ $15/hour = $4,050**.**

E. **CROSS COUNTY OR CROSS/INTER-REGIONAL PREHOSPITAL CARE -** Where the need exists, discuss the development of inter-regional prehospital patient care procedures and address issues that cross regional and/or county boundaries including the current status of any inter-regional patient care procedures, mutual aid or inter-local agreements for provision of care.

a. See Needs and Distribution of Services Reports.

Mutual Aid Agreements

At this time the mutual aid agreements are current and in place. The Council asks its county councils to update these agreements biennially in order to ensure hat they are current. Some counties have agreements with other counties, some with other regions, and in the case of Ferry County, they have an agreement that crosses the Canadian border.

- A list of these agreements is available at the Regional office upon request.

Cross County Protocols

Medical Program Directors have agreements amongst themselves regarding which Patient Care county protocols should be used in a specific county.

1. CURRENT STATUS: *List the currently designated trauma services (general and pediatric) and trauma rehabilitation services in the region.*

In the East Region 19 of the 20 facilities have applied for and received trauma designation. Deaconess and Sacred Heart Medical Centers in Spokane have applied for and received a joint Level II Adult and Pediatric Trauma Center. In the latter part of 1999, St. Joseph's Regional Medical Center in Lewiston, Idaho received a Pediatric Level III trauma designation. At that same time, Pullman Hospital received a Level III Adult trauma designation. After the Pullman designation was announced by the Department of Health, Gritman Hospital in Moscow, Idaho, requested that the they be released from the East Region EMS & Trauma System as a designated facility. At this time, the family clinic in Ione is the only facility in the region that has not been trauma designated. St. Luke's Rehabilitation Institute in Spokane is the Level I Adult and Pediatric Trauma Rehabilitation Center for the region.

A. East Region Designated Facilities

St. Luke's Rehabilitation Institute	Spokane	Level I adult and pediatric
Spokane Joint Trauma Services (a joint service of Deaconess Medical Center & Sacred Heart Medical Center)	Spokane	Levels II adult and II-Pediatric
St Joseph Regional Medical Center	Lewiston, Idaho	Level II adult and III-Pediatric
Holy Family Hospital	Spokane	Level III adult
Pullman Memorial Hospital	Pullman	Level III adult
Valley Hospital & Medical Center	Spokane	Level III adult
Deer Park Health Center & Hospital	Deer Park	Level IV adult
Lincoln Hospital	Davenport	Level IV adult
Mount Carmel Hospital	Colville	Level IV adult
Newport Community Hospital	Newport	Level IV adult
St Joseph's Hospital of Chewelah	Chewelah	Level IV adult
Tri-State Memorial Hospital	Clarkston	Level IV adult
East Adams Rural Hospital	Ritzville	Level V adult
Ferry County Memorial Hospital	Republic	Level V adult
Garfield County Hospital District	Pomeroy	Level V adult
Odessa Memorial Hospital	Odessa	Level V adult
Othello Community Hospital	Othello	Level V adult
Whitman Hospital and Medical Center	Colfax	Level V adult

B. Special Needs: *Describe facility resources in regard to trauma specialty needs such as pediatric trauma, burn care, traumatic brain injury, spinal cord injury, multi-system injuries, surgical, imaging, critical care procedures, and trauma rehabilitation for pediatric burn, TBI, spinal cord injury and orthopedic injuries.*

Special Needs Patients - Prehospital Patient Transport Guidelines (Non-Trauma)

X = Treat And Keep
ST = Stabilize And Transfer

Hospital	Maj. Medical Surgical	Major Pediatrics	Neonatal	Hemodialysis	OB	Major Burn
Deaconess	X	X	X	X	X	ST
Deer Park	ST	ST	ST / X	ST	ST / X	ST
East Adams	ST	ST	ST	ST	ST	ST
Ferry	X / ST	ST	X	ST	X	ST
Garfield	ST	ST	ST	ST	ST	ST
Gritman	X	X	ST	ST	X	ST
Holy Family	X	X	ST	ST	X	ST
Ione Clinic	ST	ST	ST	ST	ST	ST
Lincoln	ST	ST	ST	NA	X*	ST
Mt. Carmel	X	Trauma - ST Medical - X	ST X - minor	ST	X	ST
Newport	X/ST	ST	ST	ST	ST	ST
Odessa	ST	ST	ST	ST	ST	ST
Othello	ST	ST	X	ST	X	ST
Pullman	ST	ST	ST	ST	ST	ST
Sacred Heart	X	X	X	X	X	ST
St. Joseph's	ST	ST	ST	ST	ST - High Risk Only	ST
St. Luke's Rehab	Rehab	Rehab				Rehab
SJRMC-Idaho	X	X	X	X	X	ST
Tri-State	X	ST	ST	ST	ST	ST
Valley	X	ST	ST	ST	X	ST
Whitman	X	ST / X	ST	ST	X / ST*	ST

Health Care Facility Survey FY 97
***Major Burn - 2nd degree > 15 or 3rd degree > 5% BSA**
****Under 16 years**

Whitman* = High Risk
Lincoln* = Low Risk

Special Needs – Pediatric Trauma & Rehab Patients

- **Levels IV & V Designated Trauma Centers**: For the most part, these designated trauma centers stabilize and transport pediatric trauma patients to the appropriate pediatric trauma center within the region.
- **Level III Designated Trauma Centers:** These trauma centers provide some pediatric trauma care, however major pediatric trauma is transported to the appropriate Level II designated pediatric trauma center in Spokane or to the Level I pediatric trauma center, Harborview.
- **Level III Designated Pediatric Trauma Center**: The only designated Level III Pediatric Trauma Center in this region is St. Joseph's Regional Medical Center, located in Lewiston, Idaho. Those patients that require a higher level of pediatric trauma care are transported to the Level II Pediatric Trauma Center in Spokane, or to Harborview, the Level I Pediatric Trauma Center for the State of Washington.

- **Level II Designated Pediatric Trauma Center:** The joint trauma center in Spokane also has a Level II Pediatric trauma designation. They are able to treat most of the pediatric trauma that occurs within the region, but when a higher level of care is needed, patients are sent to Harborview in Seattle, the Level I Pediatric Trauma Center for the State of Washington.

- **Level I Designated Pediatric Trauma Rehabilitation**: St Luke's Rehabilitation Institute in Spokane provides pediatric trauma rehab to all pediatric patients in the region.

C. Unfilled Trauma Need: *Discuss any unfilled need for trauma services (general and pediatric) and trauma rehabilitation services in the region, and regional plans to meet these needs.*

- There are no additional needs for trauma-designated services and/or trauma rehabilitation services in the East Region.

D. Training Needs: *Identify training needs for Trauma Service and Trauma Rehabilitation Service Personnel.*

Acute Care Trauma Training

A. Include a narrative description of the trauma care workforce resources in the region including needs to additional nurses, physicians or other providers and planned solutions.

- The council is unaware of any trauma care personnel needs at any of the currently designated facilities in the region.

B. *Describe training resources currently available for trauma service personnel.*

- Since 1999 the demand for acute care trauma training reimbursement in the East Region has declined. The rural facilities, mainly levels IV and V, do not have the same trauma designation training requirements that the levels II and III have.

- Sacred Heart and Deaconess Medical Centers provide ACLS, TNCC, TNCC Instructor training, and PALS. Newport Hospital started providing ACLS classes in 1999. St. Joseph's Regional Medical Center in Lewiston, Idaho, also offers training to hospital trauma care providers in the region.

- Telemedicine is also available for use in training.

C. *Discuss remaining training needs for trauma care personnel to maintain existing level of personnel, and any planned increase in trauma care personnel within the region.*

- Designated facilities in the East Region have met the requirements for acute care trauma training. Lack of funding may cause some hardship on some of the levels 4 & 5 designated centers, which are located in the rural areas of the region.

- If facilities plan to increase their trauma care personnel, the council has not been made aware of these plans.

2. DEMOGRAPHICS – ***Identify specific demographics of the region that are likely to require additional designated trauma services or trauma rehabilitation services including total population of the region, seasonal changes, licensed drivers, licensed vehicles, miles of roads, road or traffic conditions, current or anticipated industry.***

- No additional designated trauma services or trauma rehabilitation services are needed in the East Region.

3. DESIGNATED GENERAL, PEDIATRIC AND REHABILITATION TRAUMA FACILITES: *Regional review of recommended minimum and maximum numbers of designated facilities within the region.*

a. Describe the methods used by the region to establish or re-establish the recommended minimum and maximum numbers and levels and distribution of designated trauma and trauma rehabilitation services needed in the region.

- The East Region EMS & Trauma Care Council originally recommended the number and levels of trauma services needed for this region based on patient volumes, facilities' commitment to trauma care and the existing resources.

- The Health Care Facilities Committee, has, since the original designation of trauma care centers in the East Region, reviewed the minimum/maximum recommendations for trauma designation annually. Their recommendations are forwarded to the Regional Council for adoption or revision and then are forwarded on to the Department of Health for final approval.

- The East Region's Rehabilitation Committee has been responsible for reviewing and recommending the minimum/maximum numbers of trauma designated rehab centers in the region. The committee's recommendations are forwarded to the Regional Council for review and/or revision and then are submitted to the Department of Health for final approval.

b. Specify the region's recommendations for minimum and maximum numbers and levels of designated trauma and trauma rehabilitation services using Table C. Justify changes from previous recommendations based on identified need and distribution.

TABLE C
EAST REGION
FY 02/03 Regional Plan
Min/Max Numbers for Acute Trauma Services

NO CHANGES TO THE MIN/MAX NUMBERS AT THIS WRITING.

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
II	1	2	2	1	2
III	3	4	3	3	4
IV	8	10	6	8	10
V	3	6	6	3	6
IIP	1	2	1	1	2
IIIP	1	2	1	1	2

Min/Max Numbers for Rehabilitation Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
I	1	1	1	1	1
II	0	0	0	0	0
III+	0	0	0	0	0

+ There are no restrictions on the number of Level III Rehab Services

A. DATA: *Discuss the role the Regional EMS/TC System may have in:*

1. The transition of prehospital to hospital submission of prehospital trauma data.

The East Region has had and still has the highest percentage of prehospital trauma data submitted to the state registry since the inception of the current regionally approved process was implemented in 1996. Actual prehospital data submission began in 1992 with Spokane City Fire. The process of collecting prehospital data in this region has been:

Agency → County Data Collection Site → Regional Data Collection Site → State Registry

Although the process will continue, effective July 1, 2001, the Department of Health will no longer accept prehospital data collected by the East Region for submission to the state registry.

Through this approved process the region has been able to collect not only trauma data, but also medical data. The Regional Council believed, when it started collecting data, that the process should be broad enough so that *if* there were changes to the DOH submission process at a later date, the efficiency of data submission would not be jeopardized. The Regional Council does not plan to change its current process. The Regional Council will encourage transport services to leave their run reports at the hospital where the patient is being delivered. For the most part, this is currently the approved process for rural prehospital providers.

Submitting data to the registry is identified in the current DOH approved Regional Patient Care Procedure #3 for Triage and Transport. Some of the rural areas of the region have included this process in their COPs for Triage and Transport. Whitman County, for example, has followed this process of submitting run sheets to hospitals since the implementation of the EMS and trauma system in that county. Some hospitals currently provide computers in the Emergency Rooms so that providers can complete the run sheet and also submit it to the hospital at the same time.

Not all hospitals in this region have the capabilities of providing extra equipment to prehospital providers so that run reports can be completed upon patient delivery. Another problem for some of the hospitals, especially the levels IV and V, is providing personnel to input the prehospital information. This may change with the new updates to *Collector* that will add prehospital required trauma elements to the hospital version of *Collector.*

The council has encouraged prehospital transport services to complete and leave their run sheets at the hospital at the time of patient delivery. In some cases, this process is going to take some internal revising, since not all services complete their forms on scene and have the information available to leave with the transport service.

There is also the possibility of the region becoming involved in a pilot project using a new software program sometime within in the next year or so. The software is being presented to the Inland Empire Fire Chief's Association for review. The developer of the software indicates that it will be compatible with ALL other data collection software currently being used in the State of Washington.

2. Assisting with improving the quality of prehospital trauma data collection through completion and submission of trauma patient run sheets to designated trauma services. (An example might be improving the method of getting dispatch times from communications centers.)

The East Region has been very active in encouraging prehospital providers to submit data to the state registry. The council has always encouraged transport services to leave the patient run report at the hospital at the time of patient delivery. As identified above, the Regional Patient Care Procedure #3 for Triage and Transport identifies data submission as part of the process.

Regional designated trauma centers have agreed to work with the Regional Council in the development of a reporting system that will transfer unavailable data to the receiving facility at a later date.

GOAL I: Analyze Current Regional Data.

A. Ensure that all aspects of the EMS and Trauma System are working effectively.

a. The Trauma Registry Committee will work in collaboration with the Training & Education Committee to ensure that prehospital provider training is adequate to ensure the highest quality of patient care.

b. The Trauma Registry Committee will work in collaboration with the Prehospital & Transportation Committee to ensure that verified aid and verified ambulance services are meeting standards established by WAC and/or the Regional Patient Care Procedures.

B. Identify area of the EMS and Trauma System that are not working effectively.

a. The appropriate regional committee shall address areas identified as needs.

C. Identify areas where the Injury Prevention and Public Education Committee should establish or promote prevention training.

EVALUATION OF EAST REGION QUALITY IMPROVEMENT COMMITTEE

The East Region Quality Improvement Committee continues to recognize the requirement of high quality data collected and entered into Collector. With this data in Collector, the Quality Improvement Committee can review trends and patterns in the data, and identify needed changes in patient care.

Over the past year the QI Committee has distributed suggested transfer guidelines that will help indicate when trauma patients need to be transferred to a higher level of trauma care. These guidelines were distributed to the facilities within the East Region, as well as facilities outside the region that routinely transfer patients into the region. These guidelines were developed to ensure prompt transfer and treatment at definitive care facilities when appropriate to diminish the mortality and morbidity of trauma patients of the East Region.

The committee has also worked closely with the Department of Health to refine the data reporting process specific to the needs of this committee. The committee has refined the reports generated to provide needed data to examine the complex issues identified in the East Region. Through this process, the committee has developed a reporting schedule that will streamline the report writing process for the DOH, and ensure that essential issues identified (per the QI filters listed in the plan), will be reviewed at least once per year.

The QI committee has completed and distributed the Hospital QI Handbook providing guidance and examples for those facilities still developing QI programs. The committee continues to work on the Meditech/Collector interface that is designed to transfer information from the registration module of Meditech, into Collector records when Meditech identifies the patient as a trauma patient. This process provides a shortcut to the process, and removes duplicative data entry that occurs when entering trauma patients into Collector.

This committee has also developed a regional QI newsletter that is sent to QI chairs quarterly within the state. This is being done to facilitate the communication among QI committees and the possibility of common themes among committee activities.

Currently the committee is working closely with the Injury Prevention Committee to emphasize the impact from “falls” and ways in which the communities at large can be provided preventive education.

Additionally, the committee has also identified and is investigating the incidents of pediatric maltreatment/abuse and trauma-related injuries and how this is being reported.